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ABSTRACT

"Introduction to Cognitive and Affective Skills" (NS 127) is an associate degree nursing course offered at Chattanooga State Technical Community College to help students develop competencies in decision making, communication, teaching-learning, and management. The course syllabus for NS 127 begins with information on class, laboratory, and credit hours; prerequisites; textbooks; week-by-week course content; course competencies; evaluation criteria; and curriculum coding. The bulk of the syllabus presents objectives, textual information, assignments, and questions keyed to the textbook for each of the five course units. The units focus on: (1) the analysis, planning, implementation, and evaluation phases of the decision-making process; (2) the care of patients in acute care facilities; (3) the nursing role of communicator and the therapeutic use of self; (4) the nursing role of patient teacher; and (5) the care of patients with health deviations of the musculo-skeletal subsystem. An evaluation instrument for relevant clinical behaviors is included. (EJV)

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INTRODUCTION TO COGNITIVE AND AFFECTIVE SKILLS (NS 127): COMPETENCY-BASED COURSE SYLLABUS

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COURSE SYLIABUS
Introduction to Cognitive and Affective Skills
NS 127

Class Hours: 4 Credit Hours: 7
Laboragory Hours: 9

CATALOGUE COURSE DESCRIPTION:

This course is designed to develop competencies in cognitive and affective skills necessary for the practice roles of the Associate Degree Nurse. Students will become knowledgeable in the application of the decision-making process. The processes of communication, teaching-learning, and management will be introduced and utilized. Students will begin to demonstrate an understanding of the effects of health deviations on the system as they care for patients in acute care facilities.

PREREQUISITE: NS 117 or equivalent; NS 111 or equivalent.

TEXTBOOK(S):

All books used in NS 117. In addition, the following books must be purchased:

HANDBOOK OF NURSING DIAGNOSIS, Lynda Juall Carpenito, 1st Ed; (1984) J. B. Lippincott
MERENESS' ESSENTIALS OF PSYCHIATRIC NURSING, Cecelia Monat Taylor, 11th Ed; (1982), C. V. Mosby.
INTRAVENOUS MEDICATIONS, Betty L. Gahart, 4th Ed; (1985) C. V. Mosby.
PEDIATRICS: ESSENTIALS OF PEDIATRIC NURSING, Whaley and Wong, 2nd Ed; (1985), C. V. Mosby
Fluid and Electrolyte Book

I. COURSE (Class) CONTENT:

Week		Unit	Topic
1	1/7	I	Decision-Making Process
	1/9		Decision-Making Process, continued
2	1/14		Decision-Making Process, continued
	1/16		TEST: UNIT I & LAB CONTENT
		II	Intro to Care of the Pt in an Acute Care Facility
			a. Pre-Operative Care
3	1/21		b. Intra-Operative Care
			c. Post-Operative Care
	1/23		d. Principles of Wound Healing
4	1/28		e. Fluid and Electrolyte Balance
	1/30		f. Deviations of Fluid & Electrolyte Balance

NS 127

I. COURSE (Class) CONTENT - CONTINUED:

Week		Unit	Topic
5	2/4		TEST: UNIT II & LAB CONTENT
		III	The Nursing Role of Communicator and Therapeutic Use of Self
	2/6		Communicator - continued
6	2/11		Communicator - continued
	2/13		Communicator - continued
7	2/18	IV	The Nursing Role of Patient Teacher
	2/20		Patient Teacher - continued
8	2/25		TEST: UNIT III & IV
		V	Nursing Care of Pts with Health Deviations of the Musculo-Skeletal Subsystem
	2/27		Musculo-Skeletal - continued
9	3/04		Musculo-Skeletal - continued
	3/06		Musculo-Skeletal - continued
10	3/11		COMPREHENSIVE FINAL
	3/13		NLN TESTS

COURSE (Laboratory) CONTENT:

Week		Unit	Topic
1	1/6-10		Administration of Medications a. Oral Sublingual b. Topical c. Parenteral d. Maintenance of IV's
2	1/13-17		a. Alternate Methods of Maintaining Nutritional Status b. Promotion of Wound Healing: Sterile Dressings and Wound Irrigations c. Barrier Technique

II. Competencies:

Upon completion of this course, the student will be able to:

1	10) Apply the five phases of the decision-making process in the delivery of nursing care for holistic man focusing on analysis.
1,2,3 4,5	11) Demonstrate competencies in psychomotor, cognitive and affective skills necessary to assume the practice roles of the Associate Degree Nurse.
1	12) Identify the interrelationship of the sub-systems by explaining the effects of a health deviation in one or more subsystems on holistic man.
1,2, 3,4	13) Design a nursing care plan for patients with subsystem health deviations.
1,2, 3,4	14) Manage the care of one patient with a health deviation requiring surgical intervention utilizing principles of safety and wound healing.
1,2, 4	15) Employ communicative skills in the written transmission of information regarding implementation of nursing strategies and patient adaptation.
3	16) Describe and utilize the teaching-learning process.
1,3, 4	17) Apply the principles related to fluid and electrolyte balance when caring for the patient in an acute care setting.

III. Evaluation Criteria:

A) Examinations: 3 covering specific units (objective/discussion)
1 comprehensive final (objective/discussion)
An academic average of 70% on the nursing examinations in each course is required for progression.

B) Laboratory:

1) Campus Laboratory:

a) Demonstrate safety during the application of specified skills prior to performance of those skills in the clinical laboratory.

2) Clinical Laboratory:

A student must receive a "safe" evaluation in the clinical setting for progression. An "unsafe" evaluation will result in the student not being able to progress regardless of the academic average.

III. EVALUATION CRITERIA - CONTINUED:

C. Field Work:

1. Completion of one bibliography card per week (10 per quarter) on the current week's theoretical content.
2. Completion of three care plans for patients with identified health deviations.
3. Completion of Teaching-Learning Guide included in syllabus.

D. Other Evaluation Methods: none.

E.

Average of Unit Examinations	45%
Final Examination	20%
Field Work:	
1. Bibliography cards (10)	5%
2. Nursing Care Plans (3)	20%
3. Teaching-Learning Guide	10%
Final Course Grade	100%

F. Grade Scale
90% - 100% = A
80% - 89% = B
70% - 79% = C
65% - 69% = D
below 65% = F

CHATTANOOGA STATE TECHNICAL COMMUNITY COLLEGE
Chattanooga, Tennessee
Nursing Division

Memorandum

TO: First and Second Level Students

FROM: First and Second Level Faculty

RE: TEST MAKE-UP POLICY

DATE: September 12, 1985

We as instructors realize that occasionally unforeseen circumstances prevent students from taking tests on the assigned date. Permission to postpone taking the test must be granted by a level instructor prior to the testing time. Tests must be taken within twenty-four hours of the original test date. It is the student's responsibility to make arrangements with the Testing Center for the make-up. Only one make-up per quarter will be allowed.

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LEGEND FOR CURRICULUM CODING

I. Content threads are coded superiorly while Process threads are coded inferiorly.

Content Threads	Process Threads
○ Adaptation	▲ Teaching-Learning
⏢ Safety	■ Communication
△ Growth and Development	● Nursing
═ Nutrition	⏢ Management
▱ Pharmacology	
✶ Subsystems	
◻ Pathophysiology	

II. Course Competencies are referenced back to program goals as evidenced by numbers in the left margin.

Unit and Weekly Objectives are referenced back to Cumulative Course Competencies as evidenced by numbers in the left margin.

UNIT I

		Decision-Making Process
10	●	1. Describe the five phases of the decision-making process.
10,12,13	●●	2. Define nursing diagnosis.
10,11,13, 15	●	3. Given a set of assessment data, categorize and interpret the data and formulate a nursing diagnosis for each subsystem.
10,11,15	●	4. List the nursing diagnoses in priority with the most urgent first.
10,11,12	● ○	5. For each nursing diagnosis determine the patient's adaptative state and the mode(s) of nursing intervention required.
10,11	●	6. Given a list of nursing interventions, classify them in the appropriate mode.
1,10,13, 16	●▲	7. Define the following terms: a. goal b. objective c. strategy
10,11,13, 14,16	●	8. Construct a patient goal for each nursing diagnosis specifying the appropriate mode(s) of nursing intervention.
10,11,13, 14,16	●▲	9. Develop patient objective(s) for each patient goal specifying expected outcome criteria (observable, measurable, and achievable) and expected conditions of achievement.
10,11,13, 14,15,16	●	10. Construct nursing strategies for implementation that will assist the patient in the achievement of the objectives.
10,11,14, 15	●	11. List competencies that are demonstrated during the implementation phase including the five levels of proficiency in the acquisition of a skill.
10,11,12	○ ●	12. Compare the patient's state of adaptation with previously defined objectives and goals.
		13. Document whether objectives are being met or not met and give supporting evidence utilizing current data on pertinent criteria.
10,11,12	●	14. State how evaluation leads to reassessment and a new nursing diagnosis.

UNIT I

READ: Kozier & Erb, Chapters 6 and 7
Nursing Division Student Handbook, pages 1-12
AMERICAN JOURNAL OF NURSING, 1982, 82(3) "From Novice to Expert" p 402-7.
VIEW: VT 1112 Assessment & Diagnoses: Laying the Foundation
VT 1114 Planning: The Key to Successful Outcome
VT 1115 Implementation: From Planning to Action
VT 1116 Evaluation: An End and a Beginning
COMPUTER SOFTWARE: Introduction to Nursing Diagnosis
Introduction to Behavioral Objectives
Introduction to Nursing Orders

NURSING DIAGNOSIS

The client's response to the condition, state, or situation may be expressed as:

Alteration in	Insufficient	Unresolved
Potential for	Inability to	Difficulty in
Impairment of	Failure to	Noncompliance with
Lack of	Interruption of	Nonparticipation in
Inadequate	Depletion of	Inappropriate
Deficit in	Disturbance in	Maintaining
Diminished		Reduced

Adjectives that may be helpful in clarifying are:

acute	complete	minimum
chronic	partial	occasional
full	maximum	sporadic
intermittent	mild	moderate
severe		

SITUATION

Patient: Maureen Collinson, female, 60 y/o, alert and lucid.

Physician's notes: widow of two months; steadily losing weight.

Medical diagnosis: malnutrition

Objective date:
Ht: 5'4"
Wt: 90 lbs
Temp: 101°F
B/P: 96/70 (low)
Pulse: 110 (high)
Resp: 18 (good) with no abnormal breath sounds
Peripheral pulses: present and strong
Skin: dry, pale, with poor turgor, coccyx is red
Mucous membranes: dry
Reflexes: normal
Mobility/Activity: full range of motion; too weak and dizzy to walk without help
EENT: normal
Mental: well oriented, cries off and on, tense, constantly moving hands and changing positions in bed
W/A: dark amber, concentrated urine, elevated specific gravity, negative culture
CBC: Hgb and RBC low, Het. high
Electrolytes: Na+↑ , K+ low - normal
EKG: normal
Chest X-Ray: no pathology

SUBJECTIVE DATA

PT: "I'm not surprised this happened, I knew I'd get sick if I didn't start eating more."

"I at least tried to drink fluids, but after a while I got too tired to walk to the kitchen."

States has been sleeping poorly——5 hours rest/night.

PT: "I look a mess, I'm ashamed to say I haven't had a bath all day."

"I know I'm not coping well——all I do is cry."

Based on recall—— I - 750 cc/day, O - 400 cc/day

"I haven't had a BM in 4 days."

Example

Medical diagnosis:	Chronic obstructive lung disease.
Medical order:	Withhold all cigarettes from client; no smoking.
Nursing diagnosis:	Alterations in oxygen transport related to cigarette smoking.
Goal:	The client will improve oxygen transport within 2 weeks.
Objective 1:	The client will verbalize three harmful effects of cigarette smoking by (*specific date*).
Plan:	1. The nurse and client will explore the client's knowledge of the harmful effects of smoking. 2. The nurse will use value clarification techniques to help the client express feelings about the cessation of smoking. 3. The nurse will teach basic knowledge regarding the harmful effects of smoking, using pamphlets from the American Heart Association, pictures, and charts.
Objective 2:	The client will refrain from smoking beginning (*specific date*).
Plan:	1. Behavior modification strategies will be used to assist the client in refraining from smoking; a reward system will be mutually established. 2. The client will discuss the feasibility of enrolling in a "smoke enders" program.

CHATTANOOGA STATE TECHNICAL COMMUNITY COLLEGE
Chattanooga, Tennessee
Nursing Department

NS 127

GOALS & OBJECTIVES

1.) Nsg. Dx: Alteration in metabolism related to diabetes

Goal: The patient will stabilize metabolism within one week.

Goal: The patient will decrease susceptibility to altered metabolism within one month.

2.) Nsg. Dx: Depleted nutritional state related to anorexia

Goal: The patient will develop an adequate nutritional state within one month.

3.) Nsg. Dx: Potential hazards of immobility related to recent surgery

Goal: The patient will decrease susceptibility to hazards of immobility within six days.

4. Nsg. Dx: Inadequate nutrition related to lack of knowledge of diabetic food exchange

Goal: The patient will develop adequate nutrition intake following the recommended daily allowances of the four basic food groups within three weeks.

Objectives:
1. The patient will state the four food groups and recommended servings within three days.
2. The patient will identify the importance of a balanced diet within one week.
3. The patient will incorporate the recommended ADA diet into eating patterns within two weeks.

5. Nsg. Dx: Increased susceptibility to hazards of immobility related to prolonged bed rest.

Goal: The patient will decrease susceptibility to hazards of immobility while hospitalized.

Objectives:
1. The patient will participate in four preventive measures four times a day within one day.
2. The patient will verbalize four hazards of immobility within two days.
3. The patient will identify one way to decrease susceptibility to each hazard within two days.
4. The patient will incorporate at least three preventive measures into daily routine QID within four days on patient's own volition.

Goals are based on nursing diagnoses, are a broad statement.

Objectives are stated as specific patient behavior(s) which should result from nursing actions.

Patient's Initials: _____

Room #: _____

DOB: _____

Diagnosis (Medical): _____

_____

_____

Dates of Care: _____

Student's Name: _____

CSTCC NURSING CARE PLAN

Assessment (S/O Data)	Analysis (Nursing Diagnosis)	Planning Goal Objective Nursing Orders	Evaluation (Objective met/not met as evidenced by:)

CSTCC NURSING CARE PLAN CONTINUATION

Assessment (S/O Data)	Analysis (Nursing Diagnosis)	Planning Goal Objective Nursing Orders	Evaluation (Objective met/not met as evidenced by:)

NS 127 - Introduction to Cognitive and Affective Skills

UNIT II

Introduction to Care of the Patient in an Acute Care Facility

A) Pre-Operative Care

1,14 1. Define the terms on page 1003 in Kozier and Erb.

14 2. List six (6) reasons for the performance of surgery.

9,14 3. Identify the essentials of informed consent.

9,14 4. Identify factors and common health deviations that increase surgical risk.

3,14 5. Outline important data to collect in the nursing history of a patient having surgery.

16,14 6. List common screening tests or examinations performed prior to surgery and the reasons for them.

16,14 7. Describe the following types of teaching to be carried out preoperatively:

a. moving
b. leg exercises
c. coughing and deep breathing

14 8. Identify the nurse's responsibilities for preparing the patient the day before surgery.

B) Intra-Operative Care

5,14 1. Describe nursing strategies to be carried out on the day of surgery including possible insertion of an NG tube and the preoperative preparation of the skin.

5,14 2. Describe the following types of anesthesia:

a. general
b. regional
c. local

C) Post-Operative Care

3,14 1. Identify assessment data to be collected in the initial post-operative period (in the recovery room) and on return of the patient to the nursing unit.

UNIT II

Introduction to Care of the Patient in an Acute Care Facility

3, 14 ○▭✱□ ●▲ 2. Describe the following postoperative complications, their causes, and nursing strategies to prevent them:

a. respiratory deviations (pneumonia, atelectasis, pulmonary embolism)
b. circulatory deviations (hemorrhage, shock, thrombophlebitis, thrombus and embolus formation)
c. urinary deviations (retention, infection)
d. gastrointestinal deviations (constipation, singultus, distention, nausea and vomiting, paralytic ileus)
e. psychologic deviations
f. wound deviations (infection, dehiscence, evisceration)

14 ● 3. Identify general postoperative nursing strategies to relieve discomfort and prevent complications in the patient undergoing surgery.

Read: Kozier and Erb pp. 1001-1027.
Smith and Duell pp. 659-697.
Phipps, Long & Woods pp. 401-442

View: VT 810 The Preoperative Patient: Consent, Preparation and Transfer
807 The Preoperative Patient: Nursing Assessment
808 The Preoperative Patient: Teaching and Anticapatory Guidance
811 The Postoperative Patient: Nursing Assessment
812 The Postoperative Patient: Nursing Care

Enrichment: Patras, A. The operation's over, but the danger's not. Nursing 82, September, 50-56. (On reserve.)

NS 127 - Introduction to Cognitive and Affective Skills

UNIT II

Introduction to Care of the Patient in an Acute Care Setting

D) Principles of Wound Healing

1 1) Define the terms commonly used to classify wounds.

2) Describe the inflammatory response to injury.

3) Identify the four phases of wound healing.

4) Explain each of the three types of wound healing.

5) Identify principles of tissue healing.

5 6) Develop strategies based on the principles of tissue healing which promote adaptation and closure of the wound.

6 7) Explain the clinical significance of each lab value listed on a Complete Blood Count with Differential.

Fundamentals of Nursing: Concepts & Procedures; Barbara Kozier, Glenora Erb; 2nd Edition; Addison-Wesley (1983); pp. 1029 - 1031. 187-191, 449-450/

Medical-Surgical Nursing, Concepts & Clinical Practice; Wilma J. Phippe, Barbara Long, Nance Fugate Woods; 1st Edition; C. V. Mosby (1979); pp. 442 - 447.

Laboratory Diagnostic Tests; Frances Fischback; 2nd Edition (1984); Lippincott

HEMATOPOIESIS

Hematopoiesis (the formation of blood) begins in early fetal life in the fetal liver. The progenitor (forefather) stem cell (which has not been identified yet) produces: Colony Forming Units (CFU-S) to produce red blood corpuscles (RBCs), white blood cells (WBCs), and platelets; a CFU-L to produce lymphocytes; and another stem cell like itself. The lymphocyte series produced by the CFU-L is formed and identified in the embryo—lymphocytes identifying as T cells migrate through the thymus and those becoming B cells through an unknown organ (the appendix perhaps).

CFUs belong in the bone marrow. One of the CFUs that the CFU'S produces is the CFU-E. The CFU-E creates all of the erythrocytes (RBCs) in turn through a process called erythropoiesis which is constant and "pretty much error free" (Maureen Gröer, pathophysiology lecture, Summer 1984, UTK). It begins with the production of an early primitive dividing cell called the erythroblast. The blast cell develops into a reticulocyte with an endoplasmic reticulum for the production of hemoglobin (hgb). The retic matures into a red blood corpuscle when it loses its endoplasmic reticulum and nucleus (making it no longer a true cell). It can no longer make hgb or replicate itself. It generally survives 120 days. The RBC's major function is to provide oxygen and carbon dioxide transport via the hgb. If CFU-E, blast cells, or a lot of retics are found in the blood, severe stress is indicated. If the kidney is hypoxic (as for example in the patient with emphysema) the hormone hemopoietin is secreted which stimulates the CFU-E to produce more RBCs.

The CFU-S also produces the CFU-C-GM which produces monocytes and polymorphonuclear leukocytes (PMNs). PMNs (also known as granulocytes) include neutrophils, eosinophils, and basophils. These WBCs are in the blood and tissues (probably more are in the tissues than blood). Neutrophils are involved in inflammation primarily as phagocytizing garbage disposals. Neutrophil leukocytosis (proliferation) is characteristic of bacterial and some very severe viral infections. Eosinophil leukocytosis is characterstic of allergic reactions ranging from asthma to anaphylaxis. It was believed to have been of value to primitive man when he was infested with parasites. Basophils are also involved in allergic tissue reactions as mast cells. These are potent cells releasing heparin, histamine (capable of producing the vasogenic shock associated with anaphylaxis) and other substances.

Monocytes are mononuclear leukocytes which probably do not do much in the blood but are very active in the tissue as phagocytizing macrophages—ingesting soluble antigens and releasing them marked to make contact with T helper lymphocytes to begin the immunological reaction.

In the reticuloendothelial system, macrophages attach to certain tissues (spleen, bone marrow, lymph nodes and liver) which form a loose physiological network. The system is intensely phagocytic. The liver also has Kupffer's cells which remove antigens and parasenchymal cells which detoxify them.

The CFU-S also produces the CFU-M which creates megakaryocytes (large bone marrow cells) and then platelets which are very small and act when a small vessel is injured to adhere to each other and the edges of the injury to form a plug or blood clot which then covers the area. The plug soon retracts and stops the loss of blood.

NOTE: Leukopenia means the opposite of leukocytosis. It is the word for when the WBC count is below normal limits.

NOTE: Usually in leukemia a clone of stem cells such as CFU-C-GM in myelocytic leukemia is defective.

INFLAMMATION

Any hypoxic incident anywhere in the body will cause inflammation to occur. It is happening all of the time. Only when the control mechanisms are overwhelmed are erythema (redness), edema (swelling), calor (heat), dolor (pain), or loss of function present. Inflammation is good, but it is error prone and often goes "awry" (Maureen Groer, pathophysiology lecture, Summer 1984, UTK) becoming chronic, self-perpetuating, and inadequate.

Two of the principles involved are that tissue does not respond to an invader unless there is damage and that tissue must be vascular in order for inflammation to occur (bugs don't have inflammation).

In the first stage of simple acute inflammation the dead or damaged cells release vasoactive chemicals including histamine, prostaglandins, bradykinin, and chemotactic factors creating vasodilation in surrounding arterioles and increasing the permeability of the capillaries. The purpose of this reaction is to increase the area's blood supply and to allow transitory substances to leak from the blood into the tissues. The increase in capillary permeability allows margination (WBC's line up along the wall of the capillary) and diapedesis (WBCs slither through gaps in the capillary's unruptured endothelial lining).

The first cells usually attracted to the area by the chemotactic factors are neutrophils, and they maintain a very high concentration for the initial 12 hours. Each phagocytizes 1 to 6 bacteria, liquifies them with enzymes, and then bursts from its load of accumulated pus.

In the second stage, dying neutrophils release chemotactic factors resulting in monocyte diapedesis to the site. The monocyte-macrophanges clean up the debris and secrete lytic substances to dissolve and excavate the inflamed site. They deliver enzymes including collagenase (an enzyme which disrupts connective tissue). Some macrophages burst but most recirculate to be destroyed by the reticuloendothelial system. This prepares the site for healing by regeneration or by replacement with a scar.

Why does inflammation become chronic? Reasons may include poor reserves for healing, age, and impaired immune system, or the presence of a certain organism. An example of chronic inflammation where there are cycles of attempted healing and inflammation is tuberculosis (TB). In TB the initial neutrophilia is followed by the usual migration of macrophages to the lesion, but the migration never stops and the ring of macrophages surrounding the caseous old debris never disappears.

Immunologically mediated delayed hypersensitivity differs from simple acute inflammation in that it is directly caused by an antigen-sensitized lymphocyte reaction and the resulting inflammation takes longer to develop. This is illustrated by the intradermal administration of Purified Protein Derivative (PPD) to determine if a person has had prior exposure to the TB antigen.

REFERENCES:

Goer, M.S., Shekleton, M.E. (1983). BASIC PATHOPHYSIOLOGY (2nd Ed). St. Louis: Mosby.

Thomas, C.L. (Ed) (1981). TABERS CYCLOPEDIC MEDICAL DICTIONARY (14th ed). Philadelphia: F. A. Davis.

WOUND HEALING

White Blood Cell Count (WBC)

Normal Value: 4,500 - 11,000/CU MM or 5,000 - 10,000/CU MM

Leukocytosis: increase in WBC above normal range (usually indicates infectious disease——mainly bacterial, increases with severity.)

Leukopenia: decrease in WBC below nl.

Differential count: done to identify different kinds of WBC. Represents relative numbers of various types of WBC that constitute the total WBC.

Type	% of total WBC
Neutrophils	50-70% (segs 50-65%; bands 0-5%)
Eosinophils	0-3%
Basophils	1-3%
Lymphocytes	34%

"Shift to left": increase in younger forms of neutrophils. Seen with acute stress on bone marrow or bacterial disease.

Neutrophilic leukocytosis: increase in neutrophils. Most commonly seen in bacterial infections, inflammatory disorders, tumors, physical and emotional stimuli, stresses, and drugs.

Eosinophilic leukocytosis: increase in eosinophils. Most commonly seen in allergic disorders. (Also elevated in parasitic ds.)

Basophilic leukocytosis: uncommon. Indicative of myeloproliferative ds.

Lymphocytosis: most common cause is chronic lymphocytic leukemia. (May also be elevated in infectious diseases and viral infections.)

From: Tilkian, S. Clinical Implications of Laboratory Tests. St. Louis: C. V. Mosby, 1979.

NS 127 - Introduction to Cognitive and Affective Skills

UNIT II

Introduction to Care of the Patient in an Acute Care Facility

E) Fluid and Electrolyte Balance

1, 17 1. Define the following terms:

active transport
anion
cation
colloids
crystalloids
diaphoresis
diffusion
electrolyte
extracellular fluid (ECF)
hydrostatic pressure
hypertonic
hypotonic
interstitial
interstitial fluid
intracellular fluid (ICF)
intravascular
ion
isotonic
milliequivalent
millimol
mol
obligatory loss
osmolarity
osmosis
osmotic pressure
plasma
solute
solvent

17 2. Describe factors affecting the proportion of body weight that is fluid.

17 3. Name the body's fluid compartments.

17 4. Identify major constituents (electrolytes) of intracellular and extracellular fluid compartments and body secretions.

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17		5. Describe ways in which fluids and electrolytes move through the body.
17		6. Identify ways in which osmotic and hydrostatic pressure influence movement of fluid through membranes.
17		7. Identify mechanisms that regulate the body's fluid and electrolyte volume.
17		8. Describe how these mechanisms regulate fluid and electrolyte balance.
17		9. Identify three major sources of body fluid.
17		10. Identify sources of fluid output.
17		11. Identify normal fluid intakes and outputs.
3,7,17		12. Identify essential information to obtain in a health history.
17		13. Identify ways in which selected factors influence fluid and electrolyte needs.
17		14. Describe clinical signs of the well-hydrated person.
5,17		15. Identify essential steps in measuring a person's fluid intake and output. (Review.)
3,17		16. Identify essential diagnostic tests and their significance.

Read: Kozier and Erb pp. 778-787 and 788-791.

View: VT 744 Fluid Balance
VT 745 Electrolyte Balance
VT 827 Function of Electrolytes

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NS

IN'S AND OUT'S OF FLUID MEASUREMENT

Fluid intake should exceed urine output by 500 ml/day (Nursing Skillbooks).

Minimum urinary output for an adult is 600 ml/24h.

Weight assessment is the earliest and most important indicator of fluid loss or increase.

weigh: same time (usually a-c-breakfast)
same scales
same clothing

Prevent these common sources of error in recording I and O:

1. Explain the purpose of I&O to pt, family.
2. Leave new I&O form with pencil at bedside q8h.
3. Don't "guesstimate", measure!
4. Know number of ml.'s in containers used at your hospital (cup, bowl, milk carton, etc.).
5. Get the measurements printed on top of I&O form (if not already done).
6. Post sign near ice machine of correct measurement of all containers (water pitcher, cups, bowls), popsicles and ice.
7. Count 1 full cup of ice as ½ that amount of liquid.
8. Empty and measure urinals/bedpans promptly.
9. Estimate fluid lost in incontinent urine, stool, wound exudate. Weigh dressings, pads, linen if necessary.
10. Record IV infusions carefully q8h.
11. Remind ambulatory patients to measure and record I&O.
12. Use "ready-measure" commode insert when pt is ambulatory.

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NS 127 - Introduction to Cognitive and Affective Skills

UNIT II

Introduction to Care of the Patient in an Acute Care Facility

F) Deviations of Fluid and Electrolyte Balance

1,17 1. Define the following terms:

ADH
osmolarity (osmolality)
hypercalcemia
hypokalemia
hypovolemia
oliguria
anuria
water deficit (dehydration)
water excess (overhydration, water intoxication)
extracellular fluid deficit (ECF depletion, isotonic volume deficit)
extracellular fluid excess (ECF excess, isotonic volume excess, circulatory overload)
dependent edema
pitting edema
colloids
hypernatremia
hyponatremia
hyperkalemia
hypokalemia
hypercalcemia
hypocalcemia

17 2. Identify four types of fluid imbalance.

17 3. Identify causes of water deficits and excesses.

17 4. Compare effects of water deficits and excesses.

17 5. Identify causes of extracellular fluid deficits and excesses.

3,17 6. Compare effects of extracellular fluid deficits and excesses.

3,17 7. Contrast clinical signs and laboratory findings of all types of fluid imbalances.

17 8. Contrast medical therapies required for all types of fluid imbalances.

17 9. Identify causes of specific electrolyte deficits and excesses.

Care of the Patient with Deviations of Fluid and Electrolyte Balance-Continued

3,17 ☐• 10. Identify clinical signs and laboratory findings of specific electrolyte imbalances.

17 ○▱ 11. Identify medical therapies prescribed for specific electrolyte deficits and excesses.

Read: Kozier and Erb pp. 795-804 and 807-808

View: VT 746 Fluid Loss
VT 747 Fluid Retention: Edema
VT 748 Rapid Fluid Gain
VT 865 Sodium Imbalances
VT 809 Potassium Imbalances

UNIT III

The Nursing Role of Communicator and Therapeutic Use of Self

A. Basic Concepts

11, 15	■	1. Define the communication process.
11,15	■	2. Define the following terms associated with the communication process: a. verbal b. nonverbal
11,15	■	3. Identify the influences of the following factors on the communication process: a. context b. sender c. receiver d. message e. feedback f. encoding g. decoding h. channels
10,11,15	■ ●	4. Describe the manner in which the nursing role of communicator is utilized in each of the five phases of the decision making process.
11,15,16	■	5. Describe techniques which facilitate the communication process.
11,15,16	■	6. Describe techniques which inhibit the communication process.
10,11,14,15	■ ●	7. Explain the phases of the helping relationship.
10,11,13,14, 15	■ ●	8. Discuss the purposes of the interaction necessary to obtain assessment data.
8,9	■	9. Identify own strengths and weaknesses in communication.

READ: Kozier & Erb pp. 359-367; 372-382.
Phipps, Long & Woods pp. 92-102; 113-116.

VIEW: FS 892 The Helping Interview, Parts 1, 2, 3
FS 891 Nurse-Patient Interaction:
6. The Hospitalized Person
2. The Nurse
3. Blocks to Therapeutic Communication
FS 854 Basic Patient Care: Comfort and Hygiene
1. Developing a Caring Relationship

NS 127

B. Non-Verbal Communication

11 1. Identify effects of the sociological and cultural subsystems on body language.

11 2. Explain effects of the sociological and cultural subsystems which determine boundaries of individual space.

11 3. Describe receptive and nonreceptive body language behaviors.

11 4. Distinguish among the following types of space: intimate, personal, social, and public.

11 5. Discuss potential responses which could occur when there is an intrusion on an individual's space.

11 6. Identify the effects of incongruent verbal/non-verbal behavior on the communication process.

READ: MERENESS ESSENTIALS OF PSYCHIATRIC NURSING pp. 132-133.

VIEW: FS 890 Nonverbal Communications in Nursing
1. The Silent Vocabulary
2. Kinesics: The Study of Body Language
3. Touch
4. Proxemics: Space and Human Experience

C) Verbal Communication

7	■	1) Describe characteristics of a verbal message that promote effective communication.
1,7, 11	■●	2) Discuss the following methods used for conveying messages to other health team members: a) reporting b) directing c) conferring d) referring

Mereness' Essentials of Psychiatric Nursing; Cecelia Monat Taylor; 11th Edition; C. V. Mosby (1982); pp. 128 - 131.

Audio-Visuals: VT 776 Stay in Control

D) Written Communication

9,11,15	■	1) Discuss the reasons for maintaining current, accurate records.
9,11,15	■	2) Describe guidelines that are utilized when writing records.
11,15	■	3) Identify information that is found in each part of the patient record.
3,11,15	■	4) Differentiate between subjective and objective documentation.
1,9,15	■	5) Identify terms, abbreviations and symbols that are accepted in a given institution.
9,11,15	■	6) List the components of the problem oriented record.
5,7,9, 11,15	■	7) Given patient data, record the data accurately using the problem oriented and conventional formats.
1,9	■	8) Relate legal considerations to guidelines utilized when writing records.

Fundamentals of Nursing: Concepts & Procedures; Barbara Kozier, Glenora Erb; 2nd Edition; Addison-Wesley (1983); pp. 426 - 439.

Audio-Visuals: VT 792 The Nurse, Ethics and the Law
4) Nursing Notes

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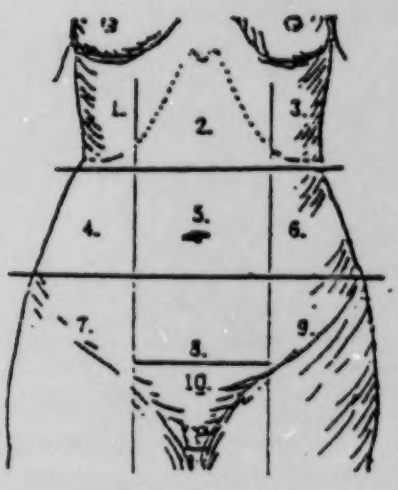
DESCRIPTIVE TERMS COMMONLY USED IN CHARTING

CONCERNING	FACTOR TO BE CHARTED	SUGGESTED TERMS TO USE
ABDOMEN	1. large and extended outward	enlarged, protuding
	2. black and blue marks present	bruised, ecchymotic
	3. hard, boardlike	rigid
	4. soft, flabby, flat	relaxed, flaccid
	5. hurts when touched	sensitive to touch, tender
	6. appears swollen, rounded	distended
	7. presence of rash	rash present (mild, severe)
	8. filled with gas	tympanites
	9. scars present	scarified

AREAS OR REGIONS OF THE ABDOMEN



1. right hypochondriac region
2. epigastric region
3. left hypochondriac region

} Upper abdomen

4. right lumbar region
5. umbilical region
6. left lumbar region

} Mid abdomen

7. right iliac region
8. hypogastric region
9. left iliac region
10. suprapubic

} Lower abdomen

CONCERNING	FACTOR TO BE CHARTED	SUGGESTED TERMS TO USE
AMOUNTS	1. large amount	1. profuse, copious, free excessive, measured amount
	2. moderate amount	2. moderate, measured amount
	3. small amount	3. small amount, scanty, slight, very little, measured amount
APPEARANCE GENERAL	1. thin and undernourished	1. emaciated
	2. fat, greatly overweight	2. obese
	3. seems very sick	3. appears acutely ill
	4. not very sick	4. does not seem acutely ill; seems moderately ill

CONCERNING	FACTOR TO BE CHARTED	SUGGESTED TERMS TO USE
APPETITE	1. very fussy about food, refuses to eat many foods	1. has definite likes and dislikes concerning food
	2. eats all food served	2. appetite good
	3. eats very little	3. appetite poor
	4. loss of appetite	4. anorexia
	5. craving for certain foods	5. parorexia
	6. refuses to eat	6. refused food (state reason)
	7. eats only small amount	7. appetite fair
	8. has desire to eat materials that are not food (chalk, dirt)	8. craves chalk, dirt, etc.
ARM	1. shoulder to elbow	1. upper arm (right or left)
	2. elbow to wrist	2. lower arm (right or left)
	3. with accumulation of fat	3. plump
	4. appear puffy or swollen	4. edematous
	5. arm artificial	5. artificial arm (right or left)
ATTITUDE MENTAL	1. not interested in surroundings	1. seems indifferent
	2. has "don't care" attitude	2. appears apathetic
	3. doesn't believe anything said	3. seems suspicious, distrustful
	4. quarrelsome, disagreeable, wants to argue	4. somewhat belligerent, quarrelsome, disagreeable
	5. afraid, worried	5. seems anxious, fearful
	6. seems to have weight of world on his shoulders	6. appears worried
	7. happy, carefree, cheerful	7. seems cheerful, optimistic
BACK AREAS	1. upper back	1. interscapular region, shoulder area
	2. small of back	2. lumbar region
	3. end of spine	3. sacral region
	4. gluteal area	4. buttocks
	5. hump back	5. kyphosis
	6. sway back	6. lordosis
	7. lateral curvature of spine	7. scoliosis
BACKREST	1. backrest raised	1. head of bed elevated (indicate angle, degree of)
BATHS	1. given when patient is admitted	1. admission bath
	2. all inclusive bath	2. complete bath
	3. including face, arms, back, axilla, genitals	3. partial bath
	4. special baths (treatment)	4. name of bath (Sitz)
	5. taken in tub	5. tub bath
	6. taken in bed, by patient	6. self-administered
BELCH	1. belching	1. eructation

CONCERNING	FACTORS TO BE CHARTED	SUGGESTED TERMS TO USE
BLEEDING	1. spurting of blood	1. in spurts
	2. very little	2. oozing
	3. nosebleed	3. epistaxis
	4. blood in vomitus	4. hematemesis
	5. blood in urine	5. hematuria
	6. spitting of blood	6. hemoptysis
	7. when bleeding is stopped	7. hemorrhage controlled
BLISTER	1. blister	1. vesicle
BLOOD PRESSURE	1. blood pressure 120/74	1. B.P. 120/74
B. M. R.	1. basal metabolic rate	1. B.M.R.
BREAST	1. inflammation of	1. mastitis
	2. each of same size	2. of equal size
	3. with sweet, fruitlike odor	3. fruity, sweet
	4. smells of alcohol	4. alcoholic
BREATHING	1. act of breathing	1. respiration
	2. act of inhaling	2. inspiration
	3. act of exhaling	3. expiration
	4. difficult breathing	4. dyspnea, retracting, grunting, flaring of nares and chin lag (terms used for children)
	5. short period when breathing ceases	5. apnea
	6. inability to breathe while lying down	6. orthopnea
	7. normal breathing	7. eupnea
	8. rapid breathing	8. hypernea, tachypnea (term used for infant)
	9. increasing dyspnea with periods of apnea	9. Cheyne-Stokes respiration
	10. large volume of air inspired	10. deep breathing
	11. small volume of air inspired	11. shallow breathing
	12. abnormal variations in rhythm	12. irregular respiration
	13. suffocation	13. asphyxia
CHEST	1. looks abnormally small	1. shrunken
	2. abnormally shaped	2. deformed
	3. hurts when moving or breathing	3. pain on moving, pain on breathing

CONCERNING	FACTOR TO BE CHARTED	SUGGESTED TERMS TO USE
CHILL	1. blanket, HWB applied to warm the patient	1. external heat applied
	2. severity (degree of)	2. severe, moderate, slight
	3. duration	3. protracted, persistent, of short duration
	4. came on suddenly	4. sudden onset
COLOR	1. colorless	1. clear
	2. of normal urine	2. amber
	3. resembling clay	3. clay-colored
	4. looks same as tar	4. tarry
	5. tinged with blood	5. blood-tinged
COMA	1. partly in coma	1. semi-comatose
	2. in deep coma	2. profound coma; does not respond to stimuli
CONSCIOUSNESS	1. fully conscious, aware of surroundings	1. alert, fully conscious
	2. only partly conscious	2. semi-conscious
	3. unconscious, but can be aroused	3. stuporous - does respond to painful stimuli
	4. unconscious, cannot be aroused	4. comatose
	5. drowsy but easily aroused	5. lethargic
CONSISTENCY	1. retains its shape	1. formed
	2. watery	2. liquid
	3. thick, sticky or gluelike	3. concentrated, tenacious
	4. containing or resembling mucus	4. mucoid
CONVULSION	1. continuous shaking	1. tonic tremor
	2. shaking with intervals of rest	2. clonic tremor
	3. began without warning	3. sudden onset
	4. spasm or convulsing seizure	4. paroxysm
	5. convulsive seizure with loss of consciousness	5. grand mal seizure
	6. localized seizure	6. focus seizure
COUGH	1. coughs all the time	1. continuous cough
	2. coughing over long period of time	2. persistent cough
	3. coughs up material	3. productive cough
	4. occurring in spasms	4. spasmodic cough
	5. coughs quite often	5. frequent cough
	6. cough that does not produce material	6. nonproductive cough
	7. with characteristic "whoop"	7. whooping cough
	8. occurs in paroxysms or attacks	8. paroxysmal cough
	9. other self-explanatory terms used to describe a cough include	9. tight, loose, deep, dry, hacking, harsh, painful, rasping, explosive, exhaustive

DECAY	1. of teeth	1. dental caries
	2. of tissue	2. necrosis
DEFECATION	1. bowel movement (material) bowel movement (act of)	1. feces, stool, defecation
	2. excessive defecation	2. diarrhea
	3. gray-colored stool	3. clay-colored stool
	4. dark brown liquid stool	4. highly colored liquid stool
	5. formed, yet soft stool	5. soft-formed stool
	6. formed with hardened feces	6. hard-formed stool
	7. black, tenacious stool	7. tarry
DIZZINESS	1. dizziness	1. vertigo
DRAINAGE	1. water, from nose	1. coryza
	2. containing pus	2. purulent
	3. bloody	3. sanguineous
	4. consists of feces	4. fecal
	5. of lymphatic fluid	5. serous
	6. contains mucus and pus	6. mucopurulent
	7. tough, sticky	7. tenacious
	8. from vagina (post-delivery)	8. lochia
	9. serum and blood combined	9. sero-sanguineous
DRESSINGS	1. a second dressing added to the first	1. dressing reinforced
	2. dressing removed, another applied	2. dressing changed
DROP	1. a drop	1. gtt.
	2. drops	2. gtts.
EARS	1. wax in the ears	1. cerumen
	2. ringing in the ears	2. tinnitus aurium
	3. dizziness	3. vertigo
	4. abnormal in shape	4. deformed
EMESIS	1. produced by effort of patient	1. induced
	2. ejected to few feet distant	2. projectile
	3. if blood is only noticeable	3. blood-tinged
	4. agent given to produce emesis	4. emetic
	5. return of solids or fluid to the mouth from the stomach	5. regurgitation
ENEMAS	1. to induce bowel movement	1. cleansing enema
	2. to supply nourishment	2. nutritive enema
	3. to relieve distention caused by gas	3. carminative enema
	4. to be retained for several min.	4. retention enema
	5. to aid in fluoroscopy examination	5. barium enema
EXPECTORATION	1. a great deal	1. profuse
	2. very little	2. scant
	3. spitting up blood	3. hemoptysis

CONCERNING	FACTOR TO BE CHARTED	SUGGESTED TERMS TO USE
EYES	1. sharpness of vision	1. visual acuity
	2. yellow in color	2. jaundiced
	3. puffy, swollen	3. edematous
	4. drooping of lids	4. ptosis of lids
	5. motionless, not moving, staring	5. fixed
	6. unusually sensitive to light	6. photophobia
	7. double vision	7. diplopia
	8. squinting-crossed	8. strabismus
	9. abnormal protrusion of eyeball	9. exophthalmos
	10. inflammation of conjunctiva	10. conjunctivitis
	11. dilation of the pupil	11. pupil dilated
	12. contraction of the pupil	12. pupil contracted
	13. nearsightedness	13. myopia
	14. farsightedness	14. hyperopia
	15. sees objects indistinctly	15. blurred vision
	16. other characteristic terms (self explanatory)	16. bright, clear, dull, inflamed, sunken, blood shot, burning, smarting
	17. stye on eyelid	17. hordeolum
FACE	1. without color	1. pale
	2. pink	2. flushed
	3. broken out	3. presence of rash, acne
	4. black and blue	4. bruised, ecchymosis
	5. characteristic expressions worn	5. anxiety, defiance, anger, pain, boredom, fear, worry, happiness, apathy, dissatisfaction
	6. marked with pits and scars	6. pock-marked
FAINT	1. fainting	1. syncope
FEET	1. reddened spots or places caused by pressure or friction	1. pressure areas present
	2. puffy, enlarged, swollen	2. swollen, enematous
	3. warm, cold	3. warm, cold
FEVER	1. without fever	1. afebrile
	2. fever, temperature above normal	2. febrile, pyrexia
	3. temperature greatly above normal (106)	3. hyperpyrexia
	4. elevated temperature suddenly returning to normal	4. crisis
	5. elevated temperature gradually returning to normal	5. lysis
	6. temperature below normal	6. hypothermia
FINGERS	1. coming to fine point at end	1. tapering
	2. square across end	2. clubbed

CONCERNING	FACTOR TO BE CHARTED	SUGGESTED TERMS TO USE
GAS	1. gas in the digestive tract	1. flatus
	2. distention caused by accumulation of gas	2. flatulence
GUMS	1. inflammation of the gums	1. gingivitis
	2. a gumboil	2. parulis
	3. pulling away from teeth	3. receding, shrunken
	4. bleed when pressure is applied	4. bleeding
	5. healthy looking	5. pink, firm
	6. spongy	6. spongy
HAIR	1. clean, good appearance	1. clean, glossy
	2. unclean, coarse	2. greasy, coarse
	3. uncombed, neglected	3. tangled, neglected
	4. not normal color	4. bleached, dyed
HALLUCINATION	1. sensory stimulation without external stimuli	1. hallucination
	2. of hearing	2. auditory hallucination
	3. of sight	3. visual hallucination
	4. of smell	4. olfactory hallucination
	5. of taste	5. gustatory hallucination
HANDS	1. dirty, rough, nails broken	1. show lack of care
	2. abnormally large	2. massive
	3. show good care	3. well kept
	4. wet, dry	4. moist, dry
	5. hot, cold	5. hot, cold
	6. shaking continuously	6. trembling
HEAD	1. forehead	1. frontal region
	2. region over temple	2. temporal region
	3. back of head	3. occipital region
	4. base of skull	4. basilar region
	5. having a large head	5. macrocephalous
	6. having a small head	6. microcephalous
HEARTBEAT	1. irregularity of heartbeat	1. arrhythmia
	2. slowness of heartbeat	2. bradycardia
	3. fast heartbeat	3. tachycardia
HIVES	1. hives	1. urticaria
	2. itching	2. pruritus
JOINTS	1. bending	1. flexion
	2. to straighten	2. extension
	3. turn downward	3. pronation
	4. turn upward	4. supination
	5. revolve around	5. rotation
	6. move away from median line	6. abduction
	7. move toward median line	7. adduction
	8. a stiff joint	8. ankylosis
	9. inflammation of joint	9. arthritis
	10. wrenching of a joint	10. sprain

CONCERNING	FACTORS TO BE CONSIDERED	SUGGESTED TERMS TO USE
LEGS	1. thigh to knee	1. upper leg (right or left)
	2. knee to ankle	2. lower leg (right or left)
LICE	1. head, body, pubic	1. pediculi
	2. condition of lousiness	2. pediculosis
LIPS	1. pale, colorless	1. pale
	2. blue in color	2. cyanotic
	3. presence of tiny cracks	3. fissured, cracked
	4. fever blisters present	4. presence of herpes simplex
LUNGS	1. abnormal sounds in	1. rales
MEDICINE (administration of)	1. by mouth	1. orally
	2. by rectum	2. rectally
	3. breathing in	3. inhalation
	4. rubbing into skin	4. inunction
	5. under the skin	5. subcutaneous
	6. within the skin	6. intradermal
	7. within the muscle	7. intramuscular
	8. within the spinal canal	8. intraspinal
	9. within the vein	9. intravenous
	10. pouring into body cavity	10. instillation
	11. into the artery	11. intra-arterial
MEMORY	1. loss of memory	1. amnesia
MENSTRUATION	1. onset of menstruation	1. menarche
	2. painful	2. dysmenorrhea
	3. total absence of	3. amenorrhea
	4. profuse or prolonged flow	4. menorrhagia
	5. occurring between periods	5. menorrhagia
	6. cessation of	6. menopause
MENTAL ATTITUDE	1. hard to please	1. seems irritable, fault-finding
	2. distrustful	2. seems distrustful, suspicious
	3. happy	3. appears optimistic, cheerful
	4. sad	4. appears depressed, moody
	5. afraid	5. appears apprehensive, anxious
	6. lacks emotional control	6. hysterical, emotional lability
MUSCLE	1. a wasting	1. atrophy
	2. inflammation of	2. myositis
	3. stretching of	3. strain
NAILS	1. blue in color	1. cyanotic
	2. other descriptive terms	2. brittle, clean, torn, manicured

CONCERNING	FACTOR TO BE CHARTED	SUGGESTED TERMS TO USE
NOSE	1. nosebleed	1. epistaxis
	2. descriptive terms	2. red, enlarged, deformed
NOURISH-MENT	1. very small amount of fluid	1. sips of fluid
	2. small pieces of ice	2. chipped ice
	3. drink of water	3. water (number of c.c.'s)
ODOR	1. pleasant	1. aromatic
	2. like fruit	2. fruity, sweet
	3. very unpleasant	3. offensive, foul
	4. belonging to particular drug or other substance	4. characteristic
PAIN	1. great pain	1. severe
	2. little	2. slight
	3. comes in seizures	3. paroxysmal, spasmotic
	4. spreads to distant areas	4. radiating
	5. started all at once	5. sudden onset
	6. other descriptive terms	6. sharp, sudden, darting, gnawing, burning, stabbing, cramping, shooting, colicky, persistent, transient, constant, shifting, localized, deep, superficial
PARALYSIS	1. of the muscles of the face	1. facial
	2. of the legs	2. paraplegia
	3. of one side of body	3. hemiplegia
	4. of a single limb	4. monoplegia
	5. of all limbs	5. quadraplegia
PATIENT (admission of)	1. walking	1. ambulatory
	2. carried (infant)	2. in arms
	3. by wheelchair	3. per wheelchair
	4. by stretcher	4. per stretcher
	5. had a bedsore when admitted	5. decubitus present on admission
PERSPIRATION	1. large amount	1. profuse, excessive
	2. small amount	2. scanty
PHYSICAL EXAMINATION	1. exam by observation	1. visual inspection
	2. exam by listening to sounds	2. auscultation
	3. exam by handling	3. manipulation
	4. exam by palpating	4. palpation
	5. exam by striking	5. percussion
	6. exam by measuring	6. mensuration

CONCERNING	FACTOR TO BE CHARTED	SUGGESTED TERM TO USE
POSITIONS	1. flat on back, arms straight at sides	1. dorsal
	2. on side, knees flexed	2. lateral
	3. on left side, left arm behind back, right leg flexed	3. Sims'
	4. head elevated, knees flexed	4. Fowler's
	5. knees flexed, head slighted elevated	5. semi-Fowler's
	6. on back, buttocks near edge of table, knees flexed and separated	6. lithotomy
	7. on back, knees flexed and apart, feet on table	7. dorsal recumbent
	8. resting on knees and chest	8. knee-chest
	9. on back, pelvis higher than head	9. Trundelenburg
	10. on abdomen, face turned to side	10. prone
	11. prone with hips over break in table and feet below of head	11. jackknife
PULSE	1. number of beats per min	1. rate
	2. rhythm	2. regular or irregular
	3. beats missed at intervals	3. intermittent
	4. over 100 beats per min	4. rapid
	5. very rapid, beats indistinct	5. running
	6. a diminished rate	6. infrequent
	7. slow in rate	7. slow
	8. one scarecely perceptible	8. thready
	9. "double pulse"	9. dicrotic
	10. according to strength	10. weak, strong
	11. readily perceived (felt)	11. perceptible
	12. cannot be felt	12. imperceptible
	13. rapid, quite distinct beat	13. pounding, bounding
REPRODUCTIVE ORGANS	1. external reproductive organs	1. genitals (external)
RESPIRATION	1. act of breathing	1. respiration
	2. above 25 respirations/min	2. accelerated
	3. induced by artificial means	3. artificial
	4. snoring	4. stertorous
	5. difficult	5. labored, dyspnea
	6. alternate periods of apnea and of increasingly deep respirations	6. Cheyne-Stokes
	7. other descriptive terms	7. quiet, sighing, gasping, rapid, shallow, deep, costal, augible, noisy
	8. absent	8. apnea

CONCERNING	FACTOR TO BE CHARTED	SUGGESTED TERMS TO USE
RESTRAINT	1. rails put on bed	1. siderails in place
	2. tied down with sheet	2. sheet restraint applied
	3. fastened to bed with ankle strap	3. ankle restraint applied
RINGS	1. rubber rings to relieve pressure	1. placed on rubber ring
	2. cotton rings applied under heels	2. cotton ring applied to each heel
SCALP	1. covered with dandruff	1. dandruff present
	2. covered with scales	2. scaly
	3. lice found	3. presence of pediculi
	4. baldness	4. alopecia
	5. other descriptive terms	5. dry, oily, itching
SENSATION	1. tingling	1. tingling
	2. of extreme heat, burning	2. burning
	3. stinging	3. stinging
	4. prickling	4. prickling
SKIN	1. normal	1. healthy
	2. pink, hot	2. flushed
	3. blue in color	3. cyanotic
	4. very white	4. extreme pallor, pale
	5. shines	5. glossy
	6. raw surface	6. excoriation
	7. yellow in color	7. jaundiced
	8. torn	8. lacerated
	9. cold and moist	9. clammy
	10. birthmark	10. nevi
	11. wart	11. verruca
	12 boil	12. furuncle
	13. other descriptive terms	13. mottled, discolored, moist dry, hot, cold. warm, oily, broken, calloused, wrinkled, tight, coarse, of fine texture, tanned
	14. indicate presence of:	14. rash, abrasion, laceration, insect bites, tumors, eruptions, acne, crusts, scars, ulcers, moles, fissures, abscess
	15. a discolored spot	15. macule
	16. a pimple	16. papule
	17. a blister	17. vesicle
	18. a pimple filled with pus	18. pustule
	19. containing colored areas	19. pigmented
	20. wet	20. moist
	21. scraped	21. abraided
	22. small red spots on skin	22. petechia
	23. area where skin is rubbed off	23. abrasion
	24. redness of	24. erythema
	25. hemorrhagic areas (bruises)	25. ecchymosis

CONCERNING	FACTOR TO BE CHARTED	SUGGESTED TERMS TO USE
SLEEP	1. slept very little	1. slept very little, slept at short intervals
	2. tired when wakens	2. awakens fatigued
	3. moans while sleeping	3. restless sleep; moaning
	4. inability to sleep	4. insomnia
SMOKE	1. smokes too much	1. smokes excessively
SOLUTION	1. having same tension as that of the blood	1. isotonic
	2. of greater tension	2. hypertonic
	3. of less tension	3. hypotonic
SPECIMEN	1. sent to laboratory	1. spec. to lab.
SPEECH	1. speaks normally	1. normal speech
	2. not understandable	2. seems incoherent; difficult to understand
	3. meaningless, wandering	3. somewhat rambling
	4. words run together	4. slurring
	5. stammering, stuttering	5. stammering, stuttering
	6. not speaking distinctly	6. inarticulate
	7. speaks long and well	7. fluent
	8. difficulty in speaking	8. dysphagia
	9. unable to speak	9. aphagia
SYMPTOMS	1. observed only by patient	1. subjective
	2. observed by someone other than the patient	2. objective
	3. unable to speak	3. syndrome
TASTE	1. as expected, as usual	1. normal
	2. like metal	2. metallic
TEETH	1. false teeth	1. dentures
	2. decay of	2. dental caries
	3. other descriptive terms	3. natural, notched, decayed, crooked, protruding, crowded, irregular, broken, loose
THROAT	1. difficulty in swallowing	1. dysphagia
	2. inability to swallow	2. aphagia
	3. other descriptive terms	3. red, swollen, inflamed, irritated
TONGUE	1. descriptive terms	1. pink, moist, dry, cracked, coated, raw, swollen, inflamed, ulcerated, scarred
TREATMENT	1. preventive	1. prophylactic
	2. offering temporary relief	2. palliative

CONCERNING	FACTOR TO BE CHARTED	SUGGESTED TERMS TO USE
THERAPY	1. water as therapeutic agent	1. hydrotherapy
	2. sunlight as therapeutic agent	2. heliotherapy
	3. x-ray, radium as therapeutic agent	3. radiotherapy
	4. drugs as therapeutic agents	4. chemotherapy
	5. florescent lights as therapeutic agent	5. phototherapy
URINATION	1. to urinate	1. void, micturate
	2. no control over urination	2. involuntary, incontinent
	3. burning when voids	3. burning sensation on micturation
	4. large amount of urine voided	4. diuresis
	5. total suppression of urine	5. anuria
	6. frequent voiding at night	6. nocturia
	7. increased amount voided	7. polyuria
	8. painful urination	8. dysuria
	9. pus in urine	9. pyuria
	10. blood in urine	10. hematuria
	11. hemoglobin in urine	11. hemoglobinuria
	12. glucose in urine	12. glucosuria
	13. albumin in urine	13. albuminuria
	14. acetone in urine	14. acetonuria
	15. bile in urine	15. choluria
	16. scantiness of urine	16. oliguria
	17. sugar in the urine	17. glycosuria
	18. bedwetting	18. enuresis
	19. stones in urine	19. calculi
WEIGHT	1. overweight	1. obese
	2. thin, underweight	2. emaciated
WOUNDS	1. deep	1. deep
	2. slight, surface only	2. superficial
	3. not infected	3. clean
	4. discharging pus	4. suppurating
	5. infected	5. infected
	6. torn	6. lacerated

E) Nursing Role of Communicator

1	■◆	1) Define patient advocate.
9,11, 14	■◆	2) Describe use of the communication process when acting as a patient advocate.

Fundamentals of Nursing: Concepts & Procedures; Barbara Kozier, Glenora Erb; 2nd Edition; Addison-Wesley (1983); pp. 85 - 86.

UNIT IV

The Nursing Role of Patient Teacher

11,16	▲	1) Describe the teaching learning process.
8,12,16	▲	2) Relate effects of internal and external factors to the outcome of the teaching learning process.
3,7,11, 16	▲	3) Describe the process and sources used for assessment of learning needs.
3,7,16	▲	4) Identify assessment data indicative of patient readiness to learn.
11,16	▲	5) Summarize the stages included in the planning phase of the teaching learning process.
3,7, 11,16	▲	6) Explain the method for construction of short-term learning goals that are observable, measurable and achievable and are based on learning needs.
1,16	▲	7) Prioritize the established goals.
2,3,7, 11,12,16	▲●	8) Develop content necessary to accomplish the established goals.
2,3,7, 11,12, 16,17	▲ ▲●	9) Select teaching methods compatible with readiness and ability to learn.
11,14,16	▲	10) Based on data gathered, structure a setting that is conducive for the implementation of the teaching learning process.
4,10, 11,16	▲	11) Develop methods for evaluation of the effectiveness of the teaching learning process.

Fundamentals of Nursing: Concepts & Procedures; Barbara Kozier, Glenora Erb; 2nd Edition; Addison-Wesley (1983); pp. 411 - 423.

Audio-Visuals:

VT 788 The Nurse Is a Teacher: Principle of Learning

FS 859 Patient Teaching: A Nursing Process Approach
1) Introduction to Patient Teaching
2) Assessment of Learning Needs
3) Planning of Teaching and Learning
4) Implementation of Teaching
5) Evaluation of Learning

Teaching-Learning Guide

Student's Name:_____ Date:_____

Patient's Init: _____ Room: _____ Diagnosis:_____

Instructor: _____

ASSESSMENT

A. Assessment of Internal Factors which Affect Learning (describe briefly)

1. Anxiety (may range from none apparent to extreme; identify source):

2. Physical status (i.e., presence of fatigue, hunger, pain, dyspnea, etc.; manual dexterity related to learning of psychomotor skills):

3. Age (predicted effects on teaching-learning process):

4. Motivation (patient's recognition of learning needs and demonstration of interest):

5. Communication skills (ability to perceive, understand, and communicate thoughts and feelings; description of barriers to or impairment of communication):

6. Senses (adequacy of vision and color perception, hearing, sensation, and smell. Document use of or need for special assistive devices such as glasses or hearing aid):

7. Education and Experience (i.e., ability to read and write; highest level of formal education completed; knowledge of vocabulary relative to health problem):

B. Assessment of External Factors which Affect Learning

1. Physical Environment (i.e., adequacy of heating, lighting, ventilation; presence of distracting noise; need for special equipment for teaching-learning process):

2. Timing (assessment of best time for patient to learn; estimation of ideal length of learning period):

C. Assessment of Learning Needs (data may be collected from the patient and/or family and from the patient's record.)
List patient's (or significant other's) learning needs by priority from most to least important (Example: "Needs to learn signs and symptoms of hypoglycemia"; "needs to learn how to give daily diabetic foot care"):

D. Identification of readiness to learn (utilize factors affecting learning previously listed for assessment):

PLANNING

A. Development of Learning Objective(s)

Directions: Choose a high-priority learning need and develop one or more specific, observable objectives related to the need. Write your objective(s) in patient-related terms utilizing an action verb such as those on the list provided with this module. Example: "The patient will explain the signs and symptoms of hypoglycemia," or "the patient will demonstrate proper diabetic foot care." (Notice how these relate to the previous examples of identified learning needs.)

Learning Objective(s):

B. Development of Teaching Content Related to Patient Objective(s) (Outline the teaching content in logical sequence for presentation):

C. Choice of Method(s) of Teaching (i.e., explanation or description, demonstration, practice, return demonstration, use of printed and audio materials, etc.):

IMPLEMENTATION

Description of implementation of teaching plan (include adjustments made to plan before or during teaching and manipulations of internal or external factors to facilitate learning):

EVALUATION

A. Assessment of Learning Relative to Achievement of Teaching Objectives

1. Were the teaching objectives met?

2. How was achievement of objectives demonstrated by the patient?

3. If specific objectives were <u>not</u> met, speculate as to reasons:

4. What changes would you make to your teaching plan in retrospect to make it more effective?

B. Description of FeedBack (Positive and/or Negative) given to Patient in Relation to Learning:

C. Evaluation of Teaching (include your choice of time, teaching plan, teaching method(s), and amount of information taught):

Unit .V

Nursing Care of Patients with Health Deviations of the Musculo-Skalatal Subsystem

A) Congenital Skalatal Deformities

1	Δ	1) Define the following terms related to congenital hip dysplasia: a) acetabular dysplasia (praluxation) b) subluxation c) dislocation
3,5,7, 11	Δ	2) Describe physical assessments which indicate the presence of congenital hip dysplasia.
5,11, 12	Δ	3) Relate therapeutic management of congenital hip dysplasia to the developmental level of the child.
,11, 14		4) Explain strategies related to the care of the child in a reduction device.
1		5) Define terminology related to clubfoot.
3,5		6) Differentiate between true clubfoot and positional deformities of the feet.
5,11, 12,14		7) Explain strategies associated with correction, maintenance of correction and follow-up of the deformity.
3,5,7, 10,11, 16	Δ	8) Using the teaching learning process, develop a teaching plan for the parents of an infant with congenital hip dysplasia or congenital clubfoot.

Pediatrics: Essentials of Pediatric Nursing; Whaley & Wong; 2nd Edition; C. V. Mosby (1985); pp. 956-962.

B) Injury to Joints and Soft Tissue

1		1) Define the following terms:
		a) contusion
		b) strain
		c) sprain
		d) dislocations
3,5, 7,11	•	2) Describe assessments indicative of contusions, strains, sprains, dislocations.
5,11, 14,17	•	3) Identify strategies utilized in the care of patients with injuries to joints and soft tissues.

Pediatrics: Essentials of Pediatric Nursing; Whaley & Wong; 2nd Edition; C. V. Mosby (1985); pp. 954-956.

Medical-Surgical Nursing, Concepts & Clinical Practice; Wilma J. Phipps, Barbara Long; Nancy Fugate Woods; 1st Edition; C. V. Mosby (1979); pp. 1025.

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C) Fractures

1.11		1) State characteristics and common treatment modalities of each of the following classifications of fractures:
		a) simple, closed
		b) compound, open
		c) comminuted
		d) greenstick
		e) complete-transverse, oblique, spiral
		f) incomplete
2,4, 11,13	Δ	2) Discuss assessments associated with fractures at all developmental levels.
11		3) Describe the use of radiography in diagnosis and follow-up care of fractures.
11,12, 13,		4) List three goals of fracture management.
11,12,13	⌓	5) Identify strategies associated with cast application and maintenance.
11		6) Summarize the purposes of traction.
11,		7) Relate scientific principles to various types of traction utilized.
3,5,7, 10,11,12, 13,	Δ⌓	8) Develop strategies for care of the patient in traction utilizing knowledge of developmental levels in the plan of care.
2,12,	Δ⌓□	9) Discuss the impact of immobilization on the psychological and sociological subsystems, relating them to developmental levels.
2		10) Describe the physiology of bone healing and remodeling.
2,11,12	★⌓□	11) List factors that affect healing, stating the rationale for each.
2,11,12	★	12) Describe biological subsystem complications related to fractures and their treatment.
	⌓ ●	13) Describe pathophysiology and strategies associated with fractures of the hip.

C) Fractures - continued

5,6, 11

14) Discuss the patient preparation necessary prior to crutchwalking.

5,11

15) Describe the following crutchwalking gaits:

a) four-point
b) three-point
c) two-point

Fundamentals of Nursing: Concepts and Procedures; Barbara Kozier, Glenora Erb; 2nd Edition; Addison-Wesley (1983); pp. 606-609.

Nursing Skills and Evaluation: A Nursing Process Approach; Sandra Smith/Donna Duell. 1st Edition; National Nursing Review of Los Altos, CA (1982); pp. 334-340.

Pediatrics: Essentials of Pediatric Nursing; Whaley & Wong; 2nd Edition; C. V. Mosby (1985); pp. 942-954.

Medical-Surgical Nursing, Concepts and Clinical Practice; Wilma J. Phippe, Barbara Long, Nancy Fugate Woods; 1st Edition; C. V. Mosby (1979); pp. 1017-1025, 961-973, 976-977; 1004-1010.

Audio-Visuals: VT 737 Care of the Patient in a Cast
VT 769 Care of the Patient in Traction
VT 757 Care of the Patient with Total Hip Replacement
VT 799 The Use of Crutches

CHATTANOOGA STATE TECHNICAL COMMUNITY COLLEGE
Chattanooga, Tennessee
Nursing Division

NS 127

TEACHING THE USE OF CRUTCHES

Three points a nurse should cover when teaching a pt how to stand c his crutches:

1) the angle of each crutch tip to corresponding ft
2) the distance of each crutch tip from the corresponding foot
3) The way to support the wt of his upper body

Place each crutch tip 4-6" to front and side of corresponding foot. Support the wt of your upper body c your hands on the handgrips.

front and side - creates a triangle for even distribution of wt (crutch tips and unaffected ft form triangle)

triangle is shallow one - each crutch tip being only 4-6" from corresponding ft - enabling pt to stand fairly straight while maintaining his balance. Supports wt of upper body on his hands rather than axillae because pressure of an axillary pad in an axilla can damage a radial nerve, leading to crutch palsy (wrist drop)

When teaching a pt how to initiate a single stride, a nurse should cover the following points:

1) direction in which to move the crutches
2) direction in which to move affected ft
3) distance by which to move the crutches
4) distance by which to move the affected foot
5) coordination of the various movements

Move your affected foot directly forward and both crutch tips forward on the side. Move the foot and the crutch tips by 12-15" from the tip of your unaffected foot. Move all three @ the same time.

A stride is initiated c a forward movement of the affected leg. Since this leg is to bear no wt, the crutches must be moved forward @ the same time. The combined forward movements develop forward momentum while enabling the pt to maintain his balance.

While moving the crutches forward, the pt must keep them on the sides; otherwise, they will obstruct the pathway of his ft. A distance of 12-15" is max by which he can move the crutches forward & setting them on the surface @ such an acute angle that they slide. By moving his affected foot directly forward also by 12-15" the pt centers most of his wt between the crutches; a longer movement would leave most of his wt behind.

When teaching a pt how to complete a stride, a nurse should cover the following points:

1) direction in which to move his unaffected foot
2) distance by which to move his unaffected foot
3) how to support the wt of his entire body while his unaffected ft is lifted

Move the tip of your unaffected ft directly forward up to the level of the crutch tips. While your unaffected ft is lifted, support the wt of your entire body & your hands on the handgrips.

By moving his unaffected ft directly forward and up to the level of the crutch tips, a pt centers all his wt between the crutches and prepares himself to initiate a new stride. While his unaffected ft is lifted, he supports the wt of his entire body & his hands on the handgrips, thus avoiding any pressure of the axillary pads in the axillas.

When teaching a pt the correct posture for standing or walking & his crutches, a nurse should cover the following points:

1) the alignment of his back
2) the position of his head

Hold your head up and keep your back straight.

By holding his head up and keeping his back st., the pt can more easily keep his balance, avoid resting his wt on the axillary pads and see obstacles in his path.

OTHER ASPECTS OF THE USE OF CRUTCHES

EVALUATING THE PATIENT FOR THE USE OF CRUTCHES

As you have seen, the proper use of crutches by a patient who is not supposed to bear weight on his leg requires adequate strength in his arms, shoulders, hands, and unaffected leg. If his arms and hands are weak, he cannot support the weight of his entire body when lifting his unaffected leg during ambulation, and if his unaffected arm, hand, and leg are weak, he cannot support his weight when getting into and out of a chair.

In addition to strength, a patient should be coordinated, able to maintain his balance, and mentally alert. Ambulation and the use of a chair each involve several movements that must be coordinated and timed in sequence, and there are brief moments during each when the patient's balance may be precarious.

Though a physician orders crutches to avoid weight bearing on a patient's affected leg while it is healing, the patient may not in fact be suited to their use. He should first be evaluated for strength, coordination, balance, and mental alertness. If there is a deficiency in any of these respects, it must be corrected before the patient is equipped with crutches and taught their use. Report your findings to the patient's physician.

EQUIPPING THE PATIENT WITH CRUTCHES

Every crutch is adjustable in two respects: its overall height, measured from the axillary pad to the crutch tip, and its handgrip level, measured from the axillary pad to the handgrip.

The overall height is important because if the crutches are too tall, the axillary pads will press into the patient's axillas. If they are too short, the patient will find them awkward to use. Pressure on the patient's axillas can also be caused by handgrip levels that are too low and awkwardness in use by handgrip levels that are too high.

The procedure for adjusting the overall height and handgrip levels of a patient's crutches is as follows:

OVERALL HEIGHT:

1. Ask the patient to take a crutch under each arm, grasping the handgrip.
2. Ask the patient to place each crutch tip four to six inches to the front and side of the corresponding foot, supporting the weight of his upperbody on the handgrips and keeping his head up and back straight.
3. Measure the vertical gap between the axillary pad and patient's axilla on each side, by inserting fingers between the two. The gap should be two fingers wide. If it is less, the crutch is too tall, and if it is more, it is too short.
4. You can adjust the overall height by sliding the central strut at the bottom upward or downward. The strut is secured by a bolt and wingnut, which must be removed beforehand and tightly secured afterward.

HANDGRIP LEVEL

1. After any adjustment in the overall height, place the patient again in the position described in steps 1 and 2 for overall height above.
2. Note the degree of flexion in the patient's elbow on each side. A flexion of 30° is correct. If the flexion is less, the handgrip level is too low, and if it is more, the handgrip level is too high.
3. You can adjust the handgrip level by sliding the handgrip upward or downward. Again, the handgrip is secured by a bolt and wing nut, which must be removed beforehand and tightly secured afterward.

TYPES OF CRUTCH-WALKING GAITS

There is more than one crutch-walking gait that may be used when a leg must be relieved of weight.

In the gait you have learned to teach a patient, the patient's weight is balanced on three points—his unaffected foot and the two crutch tips (with his hands assisting). The patient advances the crutch tip and his affected foot 12 to 15 inches and then advances his unaffected leg up to the level of his affected one. This gait is called the THREE-POINT gait.

When the patient becomes adept in the three-point gait, he may swing his unaffected foot past the level of his affected one, making for more rapid forward progress. This variation of the three-point gait is called the SWING-THROUGH gait.

The three-point and swing-through gaits are intended for patients whose legs are nonweight bearing. When a patient's leg is partially weight bearing, he can place the ball of his affected foot on the surface after advancing it and put some weight on this foot when he later advances the unaffected one. When lifting his unaffected foot, however, he should continue supporting most of his weight with his hands on the handgrips. Such a gait is called a PARTIAL WEIGHT-BEARING gait.

GETTING INTO AND OUT OF BED

A patient with a nonweight-bearing leg gets into and out of bed essentially in the same way as he gets into and out of a chair:

GETTING INTO BED

1. The patient faces one side of the bed, with his feet 12 to 15 inches away.
2. He takes both crutches under his affected arm and places his unaffected hand on the bed surface.
3. He places both crutches on or against the bed out of his way but conveniently within reach.
4. He pivots 180° toward his unaffected side and sits on the bed.
5. From the sitting position, he can swing one and then the other leg onto the bed and lie down.

GETTING OUT OF BED

1. The patient sits up, swinging one and then the other leg out of bed.
2. He uses his affected hand to place both crutches four to six inches to the front and side of his affected foot while placing his unaffected hand beside him on the bed surface.
3. He rises with a simple upward movement, bearing his weight on his unaffected leg and hand.

WALKING UP AND DOWN STAIRS

The procedure for a patient's walking up and down stairs depends on the availability of a banister.

WHEN THE STAIRCASE HAS AT LEAST ONE BANISTER

To go up the stairs, the patient does the following:

1. The patient positions himself along side the banister. The banister may be on his affected or unaffected side. If the patient has a choice, the banister on the affected side is preferable.
2. He takes both crutches under the arm opposite the banister and grasps the banister with his free hand.
3. Supporting his weight with one hand on the banister and the other holding the crutches, he lifts his unaffected foot onto the riser above.
4. Then, supporting his weight on his unaffected foot, he pulls both crutches and his affected foot onto the riser.
5. He repeats steps 3 and 4 until he arrives at the top of the stairs.

To go down the stairs, the patient does the following:

1. He positions himself along side the banister. Again, a banister on the affected side is preferable.
2. He takes both crutches under the arm opposite the banister and grasps the banister with his free hand.
3. He places both crutch tips on the riser below and at the same time swings his affected foot out over the riser.
4. Supporting his weight with one hand on the banister and the other holding the crutches, he steps down with his unaffected foot.
5. He repeats steps 3 and 4 until he arrives at the bottom of the stairs.

WHEN THE STAIRCASE HAS NO BANISTER

To go up the stairs, the patient does the following:

1. He positions himself near one or the other wall.
2. Keeping a crutch under each arm and supporting his weight thereby, he lifts his unaffected foot onto the riser above. The movement is a hopping one.
3. Then, supporting his weight on his unaffected foot, he lifts both crutches and his affected leg onto the riser.
4. He repeats steps 2 and 3 until he arrives at the top of the stairs.

To go down the stairs, the patient does the following:

1. He positions himself near one or the other wall.
2. Keeping a crutch under each arm, he places each crutch tip on the riser below. At the same time, he swings his affected foot out over the riser.
3. Then, supporting his weight on the crutches, he steps down onto the riser with his unaffected foot.
4. He repeats steps 2 and 3 until he arrives at the bottom of the stairs.

TWO GENERAL RULES

You may have noted that, whether or not a staircase has a banister, the patient initiates each upward step with his unaffected foot and each downward step with his affected one. A rule that patients find easy to remember is "Go up with the good leg and down with the bad one."

A second rule is that, whenever the pt advances his unaffected foot or his crutches, he should plant the foot or crutch tips firmly in the center of the riser.

Handout information from:
Cohen, Stephen and Viellion, Gigi
"Teaching a Patient how to Use Crutches: Programmed Instruction".
AJN June, 1979 pp 1111-1126.

3-4-85 mp

D) Curvatures of the Spine

1		1) Define the following terms: a) Kyphosis b) Lordosis c) Scoliosis
3,5, 7,11		2) Describe assessments indicative of scoliosis.
2,5, 11		3) Discuss noninvasive and invasive methods for the management of scoliosis.
3,5,7, 10,11, 12,13, 15	△ ★ ●	4) Develop strategies to be used in the care of the adolescent with scoliosis with emphasis on the psychological and sociological subsystems.

Pediatrics: Essentials of Pediatric Nursing; Whaley & Wong; 2nd Edition; C. V. Mosby (1985); pp. 966-969; 970

Michali, Lyle J., et. al. "Surgical Management and Nursing Care"; AJN September, 1979; pp. 1599 - 1607.

Medical-Surgical Nursing, Concepts & Clinical Practice; Wilma J. Phipps, Barbara Long; Nancy Fugate Woods; 1st Edition; C. V. Mosby (1979); pp. 1016 - 1017.

		K) Inflammatory Conditions Related to the Musculoskeletal Subsystem
2,11, 12,17	□ ★	1) Discuss various forms of inflammatory conditions related to the musculoskeletal subsystem.
3,11, 13,17	□ ●	2) Identify distinguishing characteristics found on assessment that are related to the various types of arthritis.
11,12, 17	□	3) Describe the pathophysiological deviations associated with arthritis.
11,12,13, 14,17	□ ●	4) Identify treatment modalities and related nursing strategies associated with arthritis.
?,11,12	□ △	5) Discuss the impact of juvenile rheumatoid arthritis on the normal growth and development of the child.
11,12,17	□	6) Identify the pathophysiological deviations associated with degenerative joint disease.
11,12,17	□	7) Describe the pathophysiology associated with the clinical manifestations of gout.
10,11,12, 13,17	□ ★ ●	8) Describe strategies associated with desired outcome criteria for patients with inflammatory conditions related to the musculoskeletal subsystem.

Pediatrics: Essentials of Pediatric Nursing; Whaley & Wong; 2nd Edition; C. V. Mosby (1985); pp. 978-982.

Medical-Surgical Nursing, Concepts & Clinical Practice; Wilma J. Phippe, Barbara Long, Nancy Fugate Woods; 1st Edition; C. V. Mosby (1979); pp. 984 - 987, 991 - 995, 996, 1000 - 1004.

Campus Lab Unit I

Administration of Medications

NS 111-121			A) Oral and Sublingual Administration of Medications
	5,11		1) List the "five rights" of drug administration.
	5,11		2) Identify three times when a medication label should be checked during preparation.
	1,11		3) Identify common abbreviations used in medication orders.
	5,11		4) State the procedure of identifying a patient before administering a medication.
	5,11, 15		5) State the information to record on the patient's chart after administering oral medications.
3	11		6) List the advantages and disadvantages of administering medications by mouth.
	5,11		7) Demonstrate the preparation and administration of oral and sublingual medications.

Fundamentals of Nursing: Concepts & Procedures; Barbara Kozier, Glenora Erb; 2nd Edition; Addison-Wesley (1983); pp. 952 - 954, 956 - 959.

Nursing Skills and Evaluation: A Nursing Process Approach; Sandra Smith/ Donna Duell; 1st Edition; National Nursing Review of Los Altos, CA (1982); pp. 257 - 262.

Audio-Visuals:	VT 404	Nursing Responsibilities
	VT 405	Preparing Medications
	VT 406	Administering Oral, Topical, Suppository and Inhalant Medications.

CHATTANOOGA STATE TECHNICAL COMMUNITY COLLEGE
Chattanooga, Tennessee
Nursing Department

NS 127

ABBREVIATIONS COMMONLY USED IN MEDICATION ORDERS

aa	of each (equal parts)
ac	before meals
ad lib	as much as desired
AM	morning
Aq	water
bid	twice a day
c	with
caps	capsules
dil	dilute
fl	fluid
h	hour
hs	hours of sleep (bedtime)
IM	intramuscular
IV	intravenous
OD	right eye
OS	left eye
os	mouth
OU	both eyes
pc	after meals
per	by
PO	by mouth
prn	when required
q	every
qd	every day
qh	every hour
q2h	every two hours
q3h	every three hours
q4h	every four hours
qid	four times a day
qod	every other day
s	without
ss	a half
Sol	solution
Stat	immediately
SQ	subcutaneous
tab	tablet
tid	three times a day
tr or tinct	tincture
ung	ointment

subcu	subcutaneous
inj	injection
liq	liquid
qam	every morning
vag	vaginal
ung	ointment
supp	suppository
susp	suspension
To	telephone order
Vo	verbal order
subling	sublingual
amp	ampule
ml	millilitar
cc	cubic centimeter
ʒ	dram
oz, ℥	ounce
mcg	microgram
mg	milligram
g or gm	gram
kg	kilogram
qt	quart
l	liter
lb	pound
gr	grain
gt	drop
gtt	drops
tsp (t)	teaspoon
Tbsp (T)	tablespoon
m	minim
mEq	milli equivalent

Adapted from: Hart, L. Dosages and solutions: a programmed presentation. St. Louis: C. V. Mosby, 1981.

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PHYSICIAN'S ORDERS

DATE & TIME	DO NOT USE THIS SHEET UNLESS A YELLOW COPY APPEARS →
1/4/84	Elixir of KCl 10% 20 m Eq po tid Multivitamins cap 1 po qd Normal Saline ½ cc Subcu q 4h prn Dr. Jones
Noted 1/4/84 8:30 a.m.	Waters, RN

Allergies

Name: Smith, Mary A

Room No.: 204 A

WHITE SHEET STAYS WITH CHART;
YELLOW COPIES GO TO THE PHARMACY.

BEST COPY AVAILABLE

Initials	Full Signature	Title	Initials	Full Signature	Title

BEST COPY AVAILABLE

MEDICATION ADMINISTRATION RECORD - 14 DAY

Enter Here IN PENCIL Number of Forms in Use

NAME Smith, Mary H

ADM. NO. Rm 204 A

DIAGNOSES Low Back Pain

ALLERGIC TO: (Record in Red)

DIET: Regular

Scheduled Medications

DR. DATE / INITIALS	D/C DATE / TIME	MEDICATION-DOSAGE-FREQUENCY-RT. OF ADM.	HR.	DATES GIVEN 1/4	1/5	1/6	1/7	1/8	1/9	1/10	1/11	1/12	1/13	1/14	1/15	1/16	1/17
1/4 LH		Elixir of KCL 10%	9	LH													
LH		20 mEq po tid	1														
1/4 LH		Multi Vitamin cap 1	9	LH													
LH		po q d.		X	X	X	X	X	X	X	X	X	X	X	X	X	X

Single Orders - Pre-Operatives

USE RED ASTERISK * TO INDICATE DOSES NOT GIVEN - EXPLAIN IN NURSE'S NOTES

DR. DATE / INITIALS	MEDICATION-DOSAGE-RT. OF ADM.	TO BE GIVEN DATE	TO BE GIVEN TIME	NURSE INITIAL	DR. DATE / INITIALS	MEDICATION-DOSAGE-RT. OF ADM.	TO BE GIVEN DATE	TO BE GIVEN TIME	NURSE INITIAL

AGE 34 RELIGION Prot. DOCTOR Jones DATE/TIME ADMITTED

RM. 204 A NAME Smith, Mary H.

Lippincott Systems, Inc.
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P/N 10194 Rev. G

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Nursing Department

NS 127

COMMON METRIC, APOTHECARY, AND HOUSEHOLD MEASURES

Metric System: Wts + Volumes	Apothecary System: Wts + Volumes	Household Equivalents
1000 ml = 1 L	60 m = 1 ʒ	60 gtt = 1 t
1000 mcg = 1 mg	8ʒ = 1ȝ	4 t = 1 T
1000 mg = 1 gm	16 ȝ = 1 pt	2 T = 1 ʒ
1000 gm = 1 Kg (2.2 lbs)	2 pts = 1 qt	(ʒ = dram; ȝ = ounce)
	4 qts = 1 gal	

Equivalencies

Household	Apothecary	Metric
1 gt	1 m	0.06 ml
15 gtt	15 m	1 ml
1 t	1 ʒ	4 ml
(1 cooking t		5 ml)
1T	4 ʒ	15 ml
2 T	1 ȝ	30 ml
1 pt	16 ȝ (1 pt)	500 ml
1 qt	2 pts (1 qt)	1000 ml
1 gallon	4 qts	4000 ml
	2.2 lbs (1 kg)	1000 gm
	15 gr	1 gm
	1 gr	60 mg
	1/2 gr	30 mg
	1/4 gr	15 mg
	1/6 gr	10 mg
	1/8 gr	8 mg
	1/60 gr	1 mg

Note:

1) 1 cc = 1 ml = 15 or 16 minims (m); 1 m = 1 gt; 1 dram = 1 t
2) Quantities in apothecaries' system often written in lower case Roman numerals. Roman numeral follows rather than precedes the unit of measure.

Examples:

ʒ = fld ounce
ʒiv = 2 fld ounces
ʒ iv = 4 fld ounces
ʒss = 1/2 fld ounce
ʒ iss = 1 1/2 fld ounces

gr vi ss = 6 1.2 grains
gr ii = 2 grains

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NS 127

ADMINISTRATION OF ORAL MEDICATION

	S	U
1. Obtains patient's medication record (drug card, medication sheet, or drug Kardex) and compares and verifies it with most recent physician's order or in accordance with other hospital policy.		
2. Washes hands and gathers necessary equipment.		
3. Selects correct medication from the drug storage area or from the medication cart. (1st check made by reading label as drug selected from storage area.)		
4. Reads label on bottle or drug package and compares to medication record before pouring medication. (2nd check.)		
5. Correctly calculates dosage if necessary. (Double checks all insulin, heparin, and I.V. digitalis drugs with a second nurse.)		
6. Pours medication from the bottle into the lid of container and then into the medication cup. (With unit dosage, takes drug package from medication cart drawer and places in medication cup. Does not remove drug from package.) If medication is a liquid: 1) shakes bottle unless contraindicated, 2) pours from side of bottle opposite label, 3) pours at eye level using thumb nail to mark dosage, 4) reads dosage at bottom of miniscus, 4) wipes bottle lip with clean paper towel if indicated.		
7. Reads medication label and compares with medication record to insure correct drug and dosage (if not prepackaged unit dose) and returns multi-dose bottle to storage area. (3rd check.)		
8. Places medication cup on tray (if not using medication cart) and takes medication tray or cart to patient's room. Checks room number against medication card or sheet.		
9. Checks patient's identaband and asks patient to state name to assure correct identification.		
10. Places patient in sitting position unless contraindicated.		
11. If prepackaged medication used, reads label, takes medication out of package, and puts into medication cup.		
12. Gives medication cup to patient and offers fresh glass of water or other liquid.		
13. Assures that patient has swallowed medication.		
14. Positions patient for comfort.		
15. Discards medication cup.		
16. Records medication as given on appropriate form.		

NS
111,
121

			B) Administering Topical Medications
	1		1) Define the following terms:
			a) topical medication
			b) instillation
			c) suppository
	3 11		2) Given a form of topical medication, state at least one therapeutic purpose for which it may be administered.
	11		3) Identify at least five body cavities to which topical medications may be administered.
	5,11		4) Describe at least two ways to observe medical asepsis while administering:
			a) eye drops
			b) ear drops
	5,11		5) Describe the correct angle for insertion of the applicator when administering a vaginal medication.
	5,11		6) Describe correct placement for a rectal suppository.
	5,11		7) Demonstrate correctly the procedures for administering:
			a) eye drops
			b) eye ointment
			c) ear drops
			d) a vaginal tablet
			e) vaginal ointment
			f) a rectal suppository

Fundamentals of Nursing: Concepts & Procedures; Barbara Kozier, Glenora Erb; 2nd Edition; Addison-Wesley (1983); pp. 975 - 980.

Nursing Skills and Evaluation: A Nursing Process Approach; Sandra Smith/Donna Duell; 1st Edition; National Nursing Review of Los Altos, CA (1982); pp. 252 - 257, 271 - 277.

NS
111.
1.

C) Preparation and Administration of Parenteral Medications

	11	▱	1) Identify the parts of a syringe and needle.
	11	▱△	2) Identify the parts of a syringe and needle that must remain sterile.
	11	▱	3) Describe two measurements used to specify a needle's size.
	11	▱	4) Define the following terms: a) parenteral medications b) intradermal injections c) subcutaneous injections d) intramuscular injections
3	11	▱△	5) List the reasons for which: a) an intradermal injection is given b) a subcutaneous injection is given c) an intramuscular injection is given
	11	▱△	6) Identify the needle and syringe size most commonly used for: a) intradermal injections b) subcutaneous injections c) intramuscular injections
	11	▱△△	7) Identify criteria used for proper selection of needle length and bore.
	11	▱△	8) State the angle and injection sites for: a) an intradermal injection b) a subcutaneous injection c) intramuscular injections
	11	▱△	9) Explain the purpose of Z-track injections.

NS 111, 121			
	11	10)	Trace correct sequence of strategies used for the administration of: a) intradermal injections b) subcutaneous injections c) intramuscular injections
	5,11	11)	State appropriate strategies used when complications resulting from administration of parenteral medications occur.
	5,11, 15	12)	List the information to be recorded on a patient's medication record or chart after administering an injection.
	5,11	13)	Practice preparing an injection, using a single-dose ampule.
	5,11	14)	Practice preparing an injection, using a multiple-dose vial.
	5,11	15)	Practice preparing an injection, using a pre-filled needle-and-cartridge unit and a Tubex and Carpoject cartridge holder.
	5,11	16)	Demonstrate the preparation and administration of intradermal, subcutaneous and intramuscular injections.
	5,11	17)	Identify special precautions to be taken when administering insulin.

Fundamentals of Nursing: Concepts & Procedures; Barbara Kozier, Glenora Erb; 2nd Edition; Addison Wesley (1983); pp. 959 - 974.

Nursing Skills and Evaluation: A Nursing Process Approach; Sandra Smith/Donna Duell; 1st Edition; National Nursing Review of Los Altos (1982); pp. 262 - 271.

Audio-Visuals: VT 407 Administering Intramuscular, Intradermal and Subcutaneous Injections

Software: Calculating & Preparing Fractional Medication Dosages for Injection
Preparing Insulins for Injection

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ADMINISTRATION OF PARENTERAL MEDICATION

Student's Name: _____ Date: _____ Route: _____

Instructor's Name: _____ Grade: _____

PREPARATION The student:	Yes	No
1. Verifies the medication order on the physician's order form with the medication sheet and ascertains that the medication, dosage, time, date and frequency are the same on both forms.	___	___
2. Washes hands.	___	___
3. Places an alcohol swab on the medicine tray.	___	___
4. Selects the appropriate syringe and needle from a variety of needles and syringes and places them on the tray.	___	___
5. Selects the correct vial from the patient's drawer and reads label while selecting (#1).	___	___
6. Reads label and compares with the medication sheet and/or medication cards (#2).	___	___
7. Checks expiration date, routes medication can be given, and clarity of medication.	___	___
8. Opens the vial.	___	___
9. Cleanses the top of the vial with an alcohol swab.	___	___
10. Injects air into the vial, maintaining sterile technique.	___	___
11. Withdraws the proper dosage from a vial, holding at eye level to determine accurate dosage.	___	___
12. Withdraws needle from vial and replaces needle cover, maintaining its sterility.	___	___
13. Reads label on the vial and compares with the medication sheets and/or medication cards (#3).	___	___
14. Places multi-dose vial back in the patient's drawer or discards the single dose vial.	___	___

ADMINISTRATION The student:	S	U
1. Takes medication to the patient on a medicine tray.	___	___
2. Identifies the patient: ID bracelet, have patient state name.	___	___
3. Explains procedure to patient.	___	___
4. Screens patient for privacy.	___	___
5. Selects the proper site.	___	___
6. Positions the patient properly.	___	___
7. Cleanses area with an alcohol swab. Allows to dry. (Circle from inner to outer area).	___	___
8. Inserts the needle into the appropriate layer of tissue at proper angle. (Injects medication in intradermal and withdraws needle).	___	___
9. Aspirates with plunger until a bubble is visible at the base of the syringe.	___	___
10. If no blood appears in the syringe, injects medication slowly and withdraws needle (intramuscular and subcutaneous).	___	___
11. If blood appears in syringe, withdraws needle without injecting medication and repeats medication preparation.	___	___
12. Massages site with alcohol swab unless contraindicated.	___	___
13. Reapplies needle cover.	___	___
14. Ascertains patient's comfort.	___	___
15. Disposes of supplies according to agency procedure, and returns the medicine tray to the medicine room.	___	___
16. Washes hands.	___	___
17. Records medication given, dosage, time, route, site, on appropriate record.	___	___

D) Maintaining Intravenous Infusions

11	▱	1) Identify equipment used for IV therapy.
5,11	▱△	2) Calculate the rate of flow for IV's.
5,11	▱△	3) Calculate the amount of time necessary for a solution to infuse.
5,11	▱△	4) Describe the process of changing IV bottles and tubings during IV therapy.
5,11	▱△	5) Describe the process of discontinuing IV's.
11	▱△	6) State the signs and symptoms of complications during IV therapy.
5,11	▱△	7) Describe the process of changing a patient's gown when she/he is receiving IV therapy.
5,11	▱△●	8) Demonstrate the strategies associated with IV therapy.
5,11, 15	▱△■	9) Discuss charting appropriate for patients receiving IV therapy.
11	▱	10) Differentiate among the mechanisms of delivery of various types of infusion pumps utilized in the clinical setting.

Fundamentals of Nursing: Concepts & Procedures; Barbara Kozier, Glenora Erb; 2nd Edition; Addison-Wesley (1983); pp. 809 - 821.

Nursing Skills and Evaluation: A Nursing Process Approach; Sandra Smith/Donna Duell; 1st Edition ; National Nursing Review of Los Altos (1982); pp. 482 - 485.

Audiovisuals: VT 409 Using Controllers and Infusion Pumps

Software: Calculating and Adjusting IV Flow Rates

Additional Resources: Woodland, Carolyn "How to Make Infusion Control Devices Work for you (Instead of Vice Versa)", RN, November 1981, pp. 59-63. (in computer lab)
Aisenstein, Terry-Jo "Those All-Too-Common IV Complications", RN, March, 1981, pp. 38-41 (in computer lab)

NS 127

UNIT II

Promotion of a Safe Environment II

A. Alternate Methods of Maintaining Nutritional Status

1		1. Define hyperalimentation including the contents of the solution.
3,6		2. Relate reasons which necessitate the use of hyperalimentation.
4,5,6		3. Describe strategies required when caring for a patient receiving hyperalimentation.
5		4. Discuss the nutritional value of commonly used intravenous fluids.
5		5. Calculate the volume of intravenous fluid infused and record appropriately.

READ: Kozier & Erb pp. 826-829.
Smith & Duell PP. 529-539, 515, 483.
_____, "Taking the Worry our of Hyperal" RN June, 1981 pp 42-48 (In resource room).

VIEW: VT 855 Hyperalimentation: Information & Procedures for Nsg
VT 804 Total Parteral Nutrition: An Overview

SOFTWARE: Testing Urine for Sugar & Ketones

B) Promotion of Wound Healing: Sterile Dressings and Wound Irrigations

1		1) Define the following terms: a) wound drainage b) exudate c) purulent d) serous sanguineous e) irrigation f) capillary action
11		2) Identify the items in a sterile dressing kit, and state the purpose of each.
11	▲●	3) Relate at least three principles of surgical asepsis to the process of applying a sterile dressing and wound irrigations.
5,11	▲●	4) Demonstrate correctly the procedure for irrigating an open wound and changing a sterile dressing.
5,11	▲●	5) Demonstrate appropriate skin care measures for the wound area, including the care of a wound with a drain.
11		6) State the reason for irrigating an open wound.
11		7) List at least three types of solutions that may be used to irrigate open wounds.
11	▲●	8) Identify actions or circumstances in wound irrigation that would constitute breaks in sterile technique.
3,11, 15	▲●■	9) Describe the information and observations to record on a patient's chart following a wound irrigation and/or dressing change.
11	●	10) Describe adaptations of strategies required when the patient has a draining wound or a wound with a drain.

Fundamentals of Nursing: Concepts & Procedures; Barbara Kozier, Glenora Erb; 2nd Edition Addison-Wesley (1983); pp. 1031 - 1037, 1039 - 1040.
Nursing Skills and Evaluation: A Nursing Process Approach; Sandra Smith/Donna Duell; 1st Ed.; National Nursing Review of Los Altos, CA (1982); pp. 128 - 135.
Audio-Visuals: VT 816 The Surgical Dressing
VT 815 Assessment of Wound Healing
VT 818 Wound Irrigation and Specimen Collection
VT 819 Closed Suction Wound Drainage

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PERFORMANCE CHECK LIST: STERILE DRESSING CHANGE

		S	U
1.	Checks physician's order.		
2.	Assembles equipment.		
3.	Explains procedure to patient and asks not to speak or touch wound during dressing change.		
4.	Washes hands.		
5.	Prepares waterproof bag for disposal of soiled dressing by turning down top edges and placing within reach. (May tape to bedside table.)		
6.	Provides privacy.		
7.	Removes tape by pulling gently toward wound.		
8.	Removes dressing carefully with hand if dressing dry, or uses disposable clean glove if dressing is moist (without dislodging drain).		
9.	Places soiled dressing in waterproof bag, without touching outside of bag.		
10.	Opens sterile dressing tray or sets up sterile supplies without violating principles of surgical asepsis.		
11.	Removes caps from any solutions to be used for cleaning wound.		
12.	Assesses wound for edema, redness and approximation of wound edges.		
13.	If drainage present, assesses amount, color, consistency, location, and odor.		
14.	Puts sterile glove on dominant hand leaving ungloved hand free to pour cleansing solution or sponges (without touching solution container to sterile sponges).		
15.	Using gloved hand cleans wound by picking up each sponge, or antiseptic swab moistened with cleaning solution, and cleans from top to bottom of incision and from center to outside. (If an irregular wound, cleans from center outward using circular motions.)		
16.	If forceps available, uses these in cleaning the wound following guidelines in 15.		
17.	Dries wound in manner described above using dry sponges.		
18.	Applies sterile dressing.		
19.	Removes gloves inside out and places in bag.		
20.	Secures dressing with tape and writes on tape date, time, and initials to document dressing change.		
21.	Assesses patient for wound discomfort and for response to dressing change.		
22.	Makes patient comfortable.		
23.	Removes all soiled materials from room.		
24.	Discards contaminated dressing in proper container.		
25.	Washes hands.		
26.	Charts dressing change and observations as appropriate.		

1-19-84

C) Barrier Techniques

5,11 1) Describe and demonstrate correct procedures for handling equipment and supplies when caring for a patient on isolation including:

a) removing soiled linens from the unit

b) disposing of used dishes and uneaten food

c) disposing of excreta

d) assessing blood pressure

e) collecting urine and stool specimens

f) transferring the patient out of the isolation unit

5,11 2) Demonstrate safe handling of apparel required for each barrier technique.

Fundamentals of Nursing: Concepts & Procedures; Barbara Kozier, Glenora Erb; 2nd Edition; Addison-Wesley (1983); pp. 459 - 464.

Nursing Skills and Evaluation: A Nursing Process Approach; Sandra Smith/Donna Duell; 1st Ed.; National Nursing Review of Los Altos, CA (1982); pp. 122 - 128.

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CLINICAL GUIDE: NS 127

1. Come prepared to preconference and clinical with completed assessment guide + medication cards, three-way pen, scissors, pen light, name tag, stethoscope if desired, + proper uniform. Neatly "groomed" please!

2. Get report on assigned pt + review Kardex. Data obtained should include such things as: v.s. - frequency + any abnl, presence of foley, NG tube, O_2 (type + flow rate) IV's (type, flow rate + amt LTC from previous shift) dfet, TPN, +/or tube feedings (type, amt, flow rate, or times of administration) I + O, NPO +/or any special fluid requirements (ie restrict or force flds) special tests or lab work to be done, D. U. testing or blood glucose testing, presence of special tubes, need for suctioning, presence of wounds or incisions (+ orders related to drsg change) comfort of pt + any prn meds given for discomfort in previous shift. Data will depend on pt problems, of course.

3. Check Medex for medications due on your shift + their times of admin. Confer with instructor about plan for med. admin. by student.(Look up any new, unfamiliar drugs in PDR, Hosp. Formulary etc before you give them.)

4. Check pt's chart. Check latest physician's orders + assure have been (or are being) transcribed. Read recent Nrs.' notes. Check "graphic" sheet - - v.s., I + O, % meals eaten, BM's, daily wts etc. Check recent lab work, + reports from diagnostic tests. (Look especially for abnl.'s)

5. Make concise notes on above to assist you in providing safe, effective care .(Consult with instructor + pt's assigned RN as indicated throughout clinical in regard to concerns, questions, or problems related to your pt.)

6. Assess pt. Introduce yourself + inform pt of time you will be caring for him. Take v.s. + do assessment. Common types of equipment, etc. you would check as part of initial assessment would include:

   (a) IV's: Check for correct type + flow rate + for properly functioning IV pump. Check date bottle, tubing + IV site hung or changed. If IV meds infusing, check for correct type + flow rate. Examine IV site for signs of phlebitis (redness, heat, pain, edema) +/or for infiltration. Ask about discomfort at site. Check to see previous shift has "cleared pump".

   (b) O_2: Check for correct type of administration + flow rate. Check humidifier bottle for adequate water level (sterile, distilled water). Check for O_2 leaks. Assure No Smoking signs in place + no O_2 hazards present.

   (c) NG tube: Check to see taped securely to nose. Check condition of nostrils. Ask about nose +/or throat discomfort. Tube pinned to gown with safety pin + rubber band? Tube properly placed in stomach, not lungs? (Check position.) If connected to suction, correct setting? (Usually low intermittent.) NG tube patent + draining? Character + amt of drainage? Tube feeding infusing per pump? Check for correct type feeding, flow rate + pt's tolerance.

(d) Dressings: Check type, location, + appearance. Clean, dry, + intact? Drainage present?—Note amt, type + source.

(e) Incisions: Note condition of wound + sutures + state of tissue healing. Note presence, character, + amt of drainage (ie, foul odor? sm, mod, lg amt drainage? serous, serosanguineous, sanguineous, purulent?) Note presence of drains + condition of skin surrounding incision. Wound edges well-approximated? Any signs of wound infection or dehiscence? Incisional discomfort?

(f) Foley: Patent + draining? Note amt + character of urine (color, clarity, odor). Taped to pt + pinned to bed with no dependent loops? Below level of bladder? Bladder distended? Complaints of discomfort related to urinary tract? (When cath care done, note condition of meatus.)

(g) Cast: Clean + dry? Assess for signs of infection (presence of drainage, "hot spots", pain, foul odor, etc). Assess for impaired circulation +/or neural function: check Color, Sensation, Temperature, Movement, + Pulse in extremity distal to cast. (Question pt about comfort — presence of pain, burning, itching, loss of sensation etc.) Edema present? Need for special positioning?

(h) Traction: Correct type + amt of wt? Weights hanging free of floor + bed? Pulley's unconstrained by knots? Traction pulling in correct direction? Check for abrasion, irritation or pressure on skin secondary to traction apparatus. Condition of pin sites? (Free of signs of infection?) Restrictions on turning + positioning?

7. After checking above plus any other equipment or tubes, do further physical assessment with major focus on systems related to pt's specific problems. Do a more general assessment of other systems. Check for safety: bed in low position? Call light secured in reach? Side rails up if indicated? Check pitcher for fresh ice water if permitted.

8. Chart: record v. s. on flow sheet + write initial assessment of pt's condition in Nrs' notes. (Instructor will check notes before they are written in chart.) Use correct abbreviations, color of ink + leave no "blank spaces". If error made, one line through + initial it. Sign name using first initial, last name + "NS, CSTCC".

9. Pour up + give meds: Remember "5 Rights" + to check label 3 times. (When pt complains of discomfort, fully assess problem—location, nature, intensity, alleviating +/or aggravating factors etc — + record in Nrs.' notes.) Before giving prn med, check Madex + Nrs' notes for date + time of last dose to see if can be given. After administration, note med given, date + time, dosage, route + site (ie rt or lt dorsogluteal, ventrogluteal, vastus lateralis, deltoid, rectus femoris, lat. aspect lt upper arm, etc.) Approx. 30 min. later reassess pt + evaluate for relief of discomfort. Chart evaluation.

10. 7:30 a.m. — serve meal: Check for correct diet. Pt NPO or on special diet for dx purposes? Assist as needed with meal. Note % eaten. Any complaints about food or problems with nutrition? Dietary referral indicated?

11. 10:00 a.m.— Reassess pt: Note any new problems or change in condition. Report, intervene, + record accordingly.

10:30-10:45 — Write final Nrs' notes: (Instructor to check all notes before entering in chart.) Check for any new lab work or special test results returned to unit + respond as appropriate.

13. 10:45 - Report off to R.N.: Use notes + Kardex as guide. Report IV LITC, Foley output in bag (don't empty) any prn's given etc. Check Kardex, Medex, Graphic Sheet, Dr's orders, + Nrs' notes for completeness before leaving.

14. 11:00 - Post Conference: Be on time + ready to share your experiences!

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CHARTING GUIDELINES

1. Recording on the chart maybe printed or handwritten except for the signature which is always handwritten. Avoid ornamental lettering.

2. Ink must be used for all recordings on the chart. Agency policies are observed for colors as they dictate specific time intervals.

3. A nurse making a series of statements should sign only once for the series except for specific medications and/or treatments. (Each statement or series of statements is preceded by the time of day in proper column.)

4. The written signature should consist of first initial and the last name and initials of your title. For example: B. Jones, NS, CSTCC. (Some agencies may require full first names.)

5. Place all recorded notations in the column in which they belong according to the various column headings. Refrain from writing across columns.

6. All entries should be significant and dignified using proper terminology and correct spelling.

7. You may abbreviate on the chart if it is correct and an acceptable abbreviation.

8. All notations should be in correct sequence with specific times noted.

9. Be sure proper headings appear on all pages added to the chart and check the dates on nurse's notes, graphic sheets, and medication records before charting.

10. Start charting at the beginning of each line—don't indent. Fill up each line. Do not skip lines, even at the bottom.

11. Begin each thought/statement with a capital letter. Periods are used at the end of each thought. Punctuate carefully.

12. Do not write complete sentences—make statements concise but meaningful. Record in a way so anyone else reading the chart will know exactly what you mean without having to guess.

13. Never word a recording in the future tense, as "Backrest to be elevated, or "Ice bag to be applied,"

14. Record <u>after</u> a medication or treatment is given, not before.

15. Don't chart what someone else has done as if you had performed the task.

16. Exact content of patient communication is valuable at times and should be placed within quotes. Ex. States (L) foot "feels like pins and needles sticking in it."

17. Avoid labeling a patient's behavior, it is best to describe it. Ex. Instead of charting "Depressed.", chart what you observe—"Non-talkative, refused lunch, refuses to get out of bed, wiping away tears at intervals."

Charting Guidelines (continued)

18. Each entry should be descriptive in itself. Avoid comparative charting--Ex. "Wound appears better, today."

19. The chart is a record within itself. All notations are in regard to the person for whom the record is kept. It is not necessary to use the word "patient" on the chart unless it clarifies the notation.

20. Do not erase a mistake; mark through the error with 1 line and write the word "error" above it with your initials, then recopy the notation, correcting the error. If you recopy a page because of many errors--you must save the old sheet in the back of the chart and mark it "recopied."

21. To be accepted as evidence, nurse's notes must be signed and the nurse must be able to identify notes and signature.

22. Legal action may be taken against a nurse if she falsifies (or helps to falsify) a hospital record.

23. A chart is the property of the hospital.

Generally,* charting should include:

1. A description of the status of the patient (assessment).
2. Nursing care given to the patient.
3. Procedures, treatments, medications administered to the patient including patient responses.
4. Entries relative to restraints/protective devices.
5. Visits by health team members other than the units' nursing staff.
6. Transportation of the patient from one area to another (including mode of transportation and name of person transferring).
7. Collection of specimens - type, amount, and their dispensation.

* More detailed charting for specific entities will be presented with each unit.

Remember: Professional charting reflects professional care.

CHATTANOOGA STATE TECHNICAL COMMUNITY COLLEGE
Chattanooga, Tennessee
Nursing Department

NS 127

Name:_____ Date Assigned to Pt.:_____

ASSESSMENT GUIDE, PART I

Pt's initials:____ Rm#:____ Age:____ Sex:____ Race:____ Religion:__ Marital Status__
Admission date:_____ Vital Signs: T__ P__ R__ BP__
Diagnosis(es), recent surgical procedures, dates recent hospitalizations:_____

Special diagnostic or evaluative tests (lab, x-ray, isotope, ECG, etc). List test, results, compare lab to norm:_____

Brief description of patient (on first appearance):_____

Allergies:_____
O_2 therapy, mode, flow rate:_____ Order date:_____
Diet, feedings:_____
Special eating problems: needs assistance____ eats independently ____ dentures____
IV fluids, rate:_____ I + O:_____ Foley cath:_____
Procedures (tube feedings, dress chg., etc):_____

Visual acuity norm:_____ Limited:_____ Glasses:_____ Blind:_____
Hearing acuity norm:____ Limited:_____ Hearing Aid:____ Deaf:____
Activity/Mobility (special orders):_____
Ambulates alone:_____ Cane:_____ Crutches:_____ Walker:_____ WC:_____
Personal Hygiene - Bath: Self____ Bed____ Limited Assistance:_____
Adjunctive Therapy (Brief description of therapy, time ordered):
Physical:_____
Occupational:_____
Speech:_____

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Pt's diagnosis(es) - Refer to current med-surg textbook (Phipps, Long, Wood)

Medical Diagnosis	Textbook Clinical Manifestations	Pt's Clinical Manifestations

Treatments: _____

Drugs (Attach drug cards) - List drugs pt. currently receiving: _____

1-19-84

NS 127

CLINICAL EXPERIENCE: OR

Use a separate piece of paper to answer these questions

9,14 1. Describe preparation of the patient on the day before and the day of surgery.

5.14 2. Describe nursing strategies implemented in the holding area.

11,14 3. Describe examples of medical and surgical asepsis observed during surgery.

3,14 4. Describe strategies implemented in the recovery room.

NS 121 6 5. State the type and method of anesthesia utilized, including rationale for use.

NS 121 6 6. List medications given during the operative experience including rationale for use.

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CLINICAL EXPERIENCE: IV THERAPY

(Use a separate piece of paper to answer these questions.)

I. Preparation for the clinical experience:

Read: Kozier + Erb pg 809 - 821, 826 - 829.

II. List the procedures you observed or assisted with during this clinical experience:

III. List the types of fluids started by IV + describe the objective of each type (see pg 810 - 811, K + E).

IV. List the major complications of IV therapy for which the nurse should assess including the common symptoms of each (K + E pg 818).

V. If you did or observed a TPN or subclavian dressing change, describe briefly how the principles of surgical asepsis (K + E, pg 467-468) were applied.

VI. Identify the benefits of having an IV therapy team in relation to the (a) patient + to the (b) staff nurse.

VII. Can you identify any drawbacks to having an IV therapy team in relation to the patient +/or staff nurse?

VIII. Evaluation:

Was this experience beneficial to you as a student? Briefly explain your answer and include any suggestions you might have for improving this experience for future students.

1-23/84

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Cumulative Weekly Clinical Objectives

NS 127

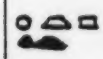
Week 3

11,14	1) Complete drug cards for all medications to be administered.
6,9, 14,15	2) Demonstrate the "5 Rights" whenever giving medications to patients.
11,14	3) Prepare medications using safety checks and appropriate equipment.
11,14	4) Administer oral, sublingual, topical and parental medications accurately.
11,14, 15	5) Record medications given appropriately.
11,14	6) Employ appropriate strategies when caring for a patient who has an intravenous infusion.
11,14	7) When required, safely perform wound irrigations and sterile dressing changes, including skin and drain care.
11,14, 15	8) Record strategies performed during wound irrigation and sterile dressing changes.
11,14	9) When required, perform all strategies necessary for the maintenance of barrier techniques.

Week 4

3,10, 11,14	1)	Formulate nursing diagnoses for each of a patient's subsystems.
10,11, 14	2)	State the patient's adaptaive state and the mode of nursing intervention that is required.
10,11, 14	3)	Prioritize nursing care.
10,11, 13,14	4)	Construct long and short-term patient goals.
10,11, 13,14	5)	Develop patient objectives.
10,11, 13,14	6)	Identify strategies for implementation.
10,11, 13,14	7)	Upon the completion of the implementation phase, compare the patient's state of adaptation with previously defined objectives and goals.
10,11, 13,14	8)	Reassess the patient and develop a new nursing diagnosis.

WEEK 5

3, 17		1. Assess assigned patients for signs and symptoms of deviations of fluid and electrolyte balance.
10,17		2. Establish nursing diagnoses related to the state of fluid and electrolyte balance of assigned patients.
13, 17		3. Plan, implement, and evaluate appropriate nursing strategies related to the promotion, maintenance, or restoration of fluid and electrolyte balance.

Week 6

3,7, 11,14, 15	1) Function in the nursing role of communicator when developing a nursing care plan for a patient.
9,11, 15	2) In the clinical setting, identify factors which influence the communication process including personal strengths and weaknesses.
9,11, 15	3) Recognize techniques which facilitate or inhibit the communication process.

11,14, 15	1) Employ techniques which facilitate the communication process.
11,14	2) Recognize the patient's nonverbal communication, devise facilitative responses and implement the selected response.
11,14	3) Utilize effective verbal communication when reporting pertinent patient information to health team members.
9,11, 14,15	4) Record patient data according to institutional and legal guidelines.
9,11	5) Identify instances in which a nurse acts as a patient advocate.
11,14, 16	6) Identify one patient learning need.

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Week 8

11,14, 16	●▲	1) Recognize internal and external factors which may affect the teaching learning process.
3,11, 14,16	▲ ●▲	2) Assess the patient for readiness to learn.
11,14, 16	●▲	3) Construct short-term learning goals.
11,14, 16	●▲	4) Prioritize the established goals.
11,14, 16	●▲	5) Develop content necessary to accomplish the established goals.
11,14, 16	▲ ●▲	6) Select teaching methods compatible with readiness and ability to learn.
11,14, 16	●▲	7) Within limits, structure a setting that is conducive for the implementation of the teaching learning process.
11,14, 16	●▲	8) Evaluate the effectiveness of the teaching learning process.

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11,13, 14,16	1) Implement strategies required for the care of patients with fractures pre and/or postoperatively.
11,14	2) When required, utilize scientific principles for the maintenance of traction.
11,14	3) Assess circulatory, neurological and musculoskeletal status of the body part in cast or traction.
11,14	4) Maintain proper body alignment of affected body part at all times.
3,11, 14	5) Observe for the effects of immobility on the biological, psychological and sociological subsystems.
11,13, 14	6) Devise and implement strategies for the care of a patient with inflammatory conditions related to the musculoskeletal subsystem.

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CLINICAL BEHAVIORS FOR NS 127

Legend: N/A Not applicable or Not Observed
1 Consistently Unsafe
2 Consistently Safe
3 Consistently Safe and Able to Adapt Delivery of Nursing Care

* Critical Behavior

I. Role as a Provider of Direct Patient Care

A. Assessment

		N/A	1	2	3
2,3,6,7 11,17	*1) Collect data according to established protocol utilizing available resources.				
	a) Assess patients with muscle-skeletal health deviations.				
	b) Assess the patient's state of adaptation pre and post-operatively.				
	c) Assess patients with fluid and electrolyte deviations.				
1,2,3,6 7,11,15	2) Identify and document changes in the patient's state of adaptation.				

B. Analysis

3,7,10, 11,12	1) Establish a nursing diagnosis based on the patient's state of adaptation.				
	a) Develop a nursing diagnosis for each subsystem using appropriate terminology.				

C. Planning

10,11, 13,15	*1) Establish priorities of care based on the nursing diagnosis.				
10,11, 13,15	2) Set goals and develop objectives in conjunction with the patient or a significant other.				
10,11, 13,15	3) Develop individualized nursing care plan based upon the nursing diagnosis and identify strategies for implementation according to established protocols.				

D) Implementation

	N/A	1	2	3
11,13,14 • 1) Initiate and complete appropriate strategies.				
a) Implement appropriate strategies pre and post-operatively.				
b) Implement appropriate strategies for the patient with a fluid or electrolyte deviation				
11,14 ○ ▱ *2) Use psychomotor, cognitive and affective skills to promote, maintain or restore the patient's optimum steady state of adaptation .				
a) Administration of medication				
1) Complete required drug cards				
*2) Calculate accurately				
*3) Use the "5 rights" for administration of medications.				
4) Administer oral, sublingual medications.				
5) Apply topical medications.				
6) Administer parenteral medications.				
7) Maintain intravenous infusions.				
b) Safety				
1) Application of bandages, binders				
2) Sterile dressings and wound irrigation				
3) Barrier techniques				

E) Evaluation

10,11,13,14 ○ • 1) Compare the patient's state of adaptation with previously defined objectives and goals				
10,11,13,14,15 ○ • ■ 2) Identify alternate strategies to promote, maintain or restore the patient's optimum steady state of adaptation, modify the plan of care accordingly and document changes.				

			NA	1	2	3
		II. Role as a Communicator				
14	●■	1) Assess verbal and non-verbal communication of patients or significant others.				
7,10,11, 14,15	●■	2) Use communication skills as a method of data collection, implementation of strategies and evaluation of care				
	●■	3) Establish and maintain effective communication with individual patients and health team members and evaluate effectiveness of this communication.				
		a) Record assessment data in appropriate patient records				
		b) Develop or contribute to the patient's plan of care.				
		c) Document completion of strategies				
		d) Document effectiveness of strategies				
11, 14, 15	○ ●■	4) Use appropriate referral sources to promote, maintain, or restore the patient's optimum steady state of adaptation.				
		III. Role as a Patient Teacher				
11, 15, 16	●■▲	1) Identify situations in which individual patients need information to promote, maintain or restore the optimum steady state of adaptation.				
		a) Communicate the identified need for teaching to appropriate health team member.				
11, 15	△ ●▲	2) Assess the patient's level of development, knowledge, and readiness.				

		N/A	1	2	3
	IV. Role as a Planner and Coordinator of Patient Care				
3,10, 11,14	1) Assess and establish priorities of nursing care a) Priorities of the patient requiring surgery. b) Priorities of the patient with fluid and electrolyte deviztions.				
	V. Role as a Member with the Profession of Nursing				
9,11	1) Demonstrate accountability for technical nursing practice within the profession's ethical and legal framework				
8.9, 11	2) Assess own performance using established criteria.				
9,14	4) Function dependently consulting a more experienced registered nurse when caring for individual patients who are not within the scope of practice.				
8,9	5) Assume responsibility for continued learning as a means of growth, development and maintenance of competencies within the scope of practice.				

Safe = A score of 2 on all critical behaviors and an average of 2 for all behaviors.

Unsafe = A score of 1 on any critical behaviors or an average of less than 2 for all behaviors.

COMMENTS:

STUDENT SIGNATURE _____ INSTRUCTOR SIGNATURE _____

DATE: _____ DATE: _____

ERIC CLEARINGHOUSE
FOR JUNIOR COLLEGES
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